			_ FOI	Department of Health and Certificate of Death	Mental Hygiei	_	28501
1	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  BETTY L VEDRAL  4a. Fecility Name (If not institution, give street and number)  JOHNS HOPKINS BAYVIEW HEDICAL G	BALTIM	SEPT O	Day Year 16 2006 4c. County of Death BALTIMORE	
	Funeral Director		5. Social Security Number  215 - 58 - 2154  Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		932 Mary	place (State or Foreign htty) Land
	Maryland a-f ehow	tor	10a. State 10b. County 10c. City, Town	imore County		1	0d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 5913 Meadow Rd.	10f. Zip Code 21206	1 -	Citizen of What Cour JSA	ntry?
036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "naturel", or iteme 23a or 28a-f ehow event, "ine Madical Examinar must be motified at	Ď	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. other than "natur vent, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) ntal Assistant	orking	. Kind of Business/In ental Indu	
land ;	nd 2 should lith and Mer 27 is marke r treumatic	To Be C	17. Father's Name (First, Middle, Last) Ephraim Vernon Young		me (First, Middle, Maid nn Schreib		
			Frank D. Vedral (Husband) 5	Mailing Address (Street and Number or F 913 Meadow Rd. Balt	imore, Md.	21206	
Baltimore,	permit. Pages 1 a Department of Hea Important: if Item eny Injury or othe			Disposition (Name of y, crematory or other place) cood Cemetery 9-1		Location - City or To ltimore, N	
Balt	permit. Departr Imports eny Inj		21. Simplified Funeral Service Licensee	²²º Yassann rundu 1 7401 Belair Rd.			6
760,	Physician // Medical // Medical // Medical // Examine prival-transit	Jical Examiner	23a. Part1. Enter the disease, or complications that be used the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the contemporary cause). Due to (or as a consequence of the contemporary cause).	AL INFARCTIO			Interval Between Onset and Death
.O. Box 68	thet the death certificate ed by the attending phy detached for use as the	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P.	quires thet n signed b uld be deta	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in ACUTE RESPERATORY DISTRE	, , ,		co use contribute to t	he cause of death? bably 4 Unknown
of Vital Records,	: The law requires thet the cete has been signed by th page 2 should be detache.	Completed	MULTILOBAR PNEUMONIA SEPSIS A COTE RENAL FAI	LURE	24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
of Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 Residence		fy)
Division (	To the Hospitel or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	1 Natural 5 Pending (Month, Day Year) I	Time of njury at Work?  M 1 Yes 2 No	28d. Describe how	njury occurred t and Number or Rur	al Bouto Number
Div	pitel or A		4 Homicide determined building, etc. (Specify)		City or Town, S	fate)	
	the Hos thin 24 ho the Fun mpletely (	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Certifying Physician: To the best of my knowledge (Check only one) American Indiana	d/or investigation, in my opinion, death occurred at the time, date and plat diversity and the time, date an		and place, and due to Date signed (Month)	
	F 3 F 8		Alisha worde, MBS	RESOO 1	S	ept 6, 200	56
	12		30. Name and address of person who completed cause of death (Item 23a) HEDI CAC CENTER, 4940 ENSTERN AVEN  31. Date filed (Month, Day, Year)	IVE, BALTIMORE, 1	TARYLAND	21224	ENVIEW
	Sta Regist		31. Date filed (Month, Day, Year)  SEP 0 8 2006  32. Agistrar's Signature	Specie			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 U U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, 2006 **Physician** Rosa P. Vilella 9:04 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 24, 1928 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 77 Yrs. Director 217-98-4049 Spain Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode! item 27 is marked other than "natural", or itema 23a or 28a-f sho other traumatic event, the Medical Expunser must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8701 Yarmouth Court 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2 No fYes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White δ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be i 2 should be fi h and Mental H 7 ie marked of Jose Porta Josefa Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 to Department of Heelth at Importent: if item 27 to eny injury or other traus Federico G. Vilella / Son 8701 Yarmouth Court, Potomac, Maryland 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 8, 2006 Bethesda, Maryland 21. Signature of Funeral Service Scenses 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. pod Mydette brisa M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): Examiner Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and is be detached for use es the burial-transit Myocardial Infarction Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ icete has been sig r, page 2 should b Sepsis, Acute Renal Failure, Pneumonia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificete has intuneral director, page 2 s autopsy performed? 2□ No 1 Yes 2 No 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 🎇 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending death. м 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63053 2006 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard E. Burgess, M.D. 10 Center Drive, Bldg. 10, Bethesda, Maryland 20892 32. Registrar's Signature 31. Date filed (Month, Day, Year) State GOBALL'S 08 2006 Registrar

			1 - For State Registrar	State of Man		artment of ertificate o		-	giene Reg. No. $200$	6 28503	
	Physic		Decedent's Name (First, Middle,     Audrey Elaine					2. Date of De Month	Day Ye	3. Time of Death	
•	/Med Exam		4a. Facility Name (If not institution,	give street and number)		-	n, or Location of Dea	th	4c. County of 0		
	Funera Directo		215-22-1534	5. Sex 7. Age (i	n yrs. last birthday 78 Yrs.	Months Day	ar If Under 24 Hr ys Hours Mir		y, Year) 9, 1928	Birthplace (State or Foreign Country) Maryland	
	haryland enow	or	Usual Residence of Decedent  10a. State 10b. County  MD Ba1	timore	Oc. City, Town or L Lat	ocation nsdowne				10d. Inside City Limits 1 ☐ Yes 2 📉No	
	th the N or 28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	,	
	Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. It other then "natural", or items 23a or 28a-f show event, its Madical Examinar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	If Yes, Give X		Was Decedent of If Yes, specify C	21227 of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	United S  14. Race - / Black, V  Specify:	tates American Indian, White, etc. White	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural; or any injury or other traumatic event, the Madical Examinations.	Completed by	3 Mwidowed 4 □ Divorced  15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Oce e kind of work do DO NOT use ret	ne during most of w	orking	16b. Kind of Business/Industry		
	212 led with lygiene her the	Com	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		Sales	Associat			ail	
	land id be fil kenta! H ked oti	To Be	17. Father's Name (First, Middle, L Herbert Stans						Anna Pred	liger	
	Maryla 2 should and Men 1 marke	-	19a. Informant's Name/Relationshi	p (Type, Print)					er, City or Town, Sta		
	ore, health of Health of Health of Health or Item 27		Sandra Lake - D  20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City		
	timor t. Pages rtment of I rtant: If it		1	ecity)	Crestlaw Garden	n Memori	19 <b>-</b> 9.	-2006	Marriotts meral Hom	sville, MD	
	Departiment Import		Lo but C	Lamel &	2	719 Hamm	nonds Fry	nbrose fi Rd., Lar	meral Hom nsdowne, M	ne, Inc. ID 21227	
	Physician /Medica		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on eachtine.	e death. Do not en			ac or respiratory ai	rrest,	Approximate Interval Between Onset and Death	
E	8760, ate be executed at the burial-transit and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	ASTAT consequence of):	IC LL	NG CA	NCER		3 YEARS	
RE	ords, P.O. Box 61 requires that the death certific een signed by the attending pl hould be detached for use as!	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify,			23d. Date of Month	delivery Day Year	
AU	rds, P. ( quires that the n signed by uld be detact	d by Ph	Part II. Other significant condition	as contributing to death but r	not resulting in the (	underlying cause	given in Part I.	23e. Did t	_	te to the cause of death?  Probably 4 Unknown	
m	aw aw	Complete						24a. Was autor perfo 1 ☐ Yes	prior deat	e autopsy findings available to completion of cause of h? Yes 2 No	
Z	Vital F sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	at 2□ DOA		eath Check only o	one) dence 6 □Other (	Sanatal	
VA	Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	atlon: To	27. Manner of Death  1  Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Y		of 28c. Ir	njury at Vork?		how injury occurred	ър <b>в</b> спу)	
V.	Division Hospital or Attendi 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Could no 4 Homicide determin		- At home, farm, si (Specify)	treet, factory, offic	се	28f. Location (S City or Tox	Street and Number own, State)	r Rural Route Number,	
	Hospital 24 hours Funeral	Medical		Physician: To the best of r xaminer: On the basis of ex and manner state	camination and/or is						
	To the routhin 2 routher complet	Me	29b. Signature and title of certifier	AICOL	` A / -		ense number		29d. Date signed (N		
	10		30. Name and address of person w	ho completed cause of deal	th (Item 23a) (Type	Print) EDI	CAL ST	AFF C	SEPT OFFICE,	05 2006	
	s	tate	31. Date filed (Month, Day, Year)	R PRAK	Signature	'ST A	GNES	HOSPIT	AL)	SACITADRE	
	Regis		SED O R	2006	Ro	8-10-					

	1	State Registrar	atl		Ce	rtificate of	Death	7		Reg. NZ	UUb	28504
siciar		1. Decedent's Name (First, Middle, La	*	( N/-	1. ~ 1	Ho Non	.0)		2. Date of De Month		200 C	3. Time of Death
edica		Julia  Aa. Facility Name (If not institution, give	e street and number)	(100	1412	4b. City, Town,		of Death	69		unty of Death	
mine		Horkins Elder Plus	6-	10	ring	Edge.			>			County
eral		5. Social Security Number 6. 5	Sex 7. Age	(In yrs. la	ast birthday)		r If Unde	r 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Foreign ntry)
tor		212-10-5316	□M 20XF	8	7 Yrs.	Months Days	Hours	Min.	MAY 28	1919		ryland
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
3		Maryland Baltin	oro	,		Baltimor	•					1 ☐ Yes 2 📉 No
October Constitution of Property of Proper	2	10e. Street and Number	IOLC			10f. Zip Code	.е			10g. Citízer	of What Cou	intry?
	2	1419 Sussex Roa	hd				21 221				USA	
1	runerar Director	11. Marital Status	12. Was Decedent I	Ever in U.S	3. 13.	Was Decedent of If Yes, specify Cul	Hispanic O	rigin? (Spe an. Puerto	ecify Yes or No	o- 14.	Race - Ameri Black, White	
		1 Never Married 2 Married	1 Tes 2 X	10		1 ☐ Yes 2 ဩrNo			, , ,	1		
7	og på	3 XWidowed 4 □ Divorced	Year or Dates:		16a Daga	dent's Usual Occu					VV	hite
1	Completed	15. Decedent's E (Specify only highest gri	ide completed)		(Give	kind of work done DO NOT use retire	ipation e during ma ed)	st of worki	ing	160. King	of Business/Ir	idustry
8	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)		.dal Sean				Br	ida1_Sh	าดก
	90	17. Father's Name (First, Middle, Last							(First, Middle			.ор
	2 _	Aleksander E	lusiewicz					2	Zafia H	[andza]	L	
		19a. Informant's Name/Relationship (				ng Address (Stree						p Code)
	4	Cheryl McElwee/N	iece	20h DI	141	.2 Old Jo	pppa F	Road	Joppa,			
1	1	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 [				osition (Name of matory or other pla					ion - City or T	
1	-	<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>		Met	ro Cr	ematory,	Inc.	9/1/	, OO	Ba	ltimor	e, MD
1		Elimanin	gorchik		2	99 Freda	rick	Road	halli Talti	SOC16	MD 212	MD, Inc.
		23a. Part 1. Enter the disea e, or comshock, or heart failure. List only		the death							1117 212	Approximate
n	1	Immediate Cause (Final		10. entic								Interval Between Onset and Death
		disease or condition resulting in death)	aDue to (or as									years
ı		Convention that appropriate	b	·								
200	<u> </u>	Sequentially list conditions, I any Tauding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as:	a consequ	ence of							
2.0	77	Cause (Disease or injury that initiated events resulting in death) Last	c									
ú	Cal	, coding in doubly back	Due to (or as	a consequ	ence or):							
			_ d									
/Mg	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of deliv	erv
0	2	in the past 12 months?	1 □Live birth 4□Pregnant at			□Ectopic pregnano □ Other (specify)	cy			1	Month	Day Year
hire	riiysiciari/med	9 Unknown	9□ Unknown									
O XX	y	Part II. Other significant conditions		ut not resu	lting in the u	nderlying cause g	iven in Part	t I.	23e. Did	tobacco use	contribute to t	the cause of death?
70	3	Diabetes N	ellitus						1 🗆	Yes 2. ☑K	lo 3□Pro	bably 4 □Unknown
2	ombiered								24a. Was		4b. Were auto	opsy findings available empletion of cause of
1	5								perfo	2 No	death? 1 🗌 Yes	2 No
ď	מ	25. Was case referred to medical examiner?	Hospital:	<u></u>					(Check only		A-<5.)r	od living
11-		1 Yes 2 No 27. Manner of Death	1 Linpatie		28b. Time o	IL 3 DOA			me 5 Resi 28d. Describe			(v) Facility
200		1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year)	Injury	W	ork? ⊒Yes 2.[		zou. Describe	now injury or	ccurred	11531
610	20	3 Suicide 6 Could not b	θ 29a Place of Init	ury - At ho	me, farm, st	reet, factory, office			28f. Location (	Street and N	umber or Run	al Route Number,
100	Ceruncation	4 Homicide	building, etc	c. (Specify	)	,,,			City or To	wn, State)		
		29a. Certifier 1 Certifying Pi	ysician. To the best	of my know	wiedge, deal	h occurred at the	time, date a	and place,	and due to the	cause(s) an	d manner as s	stàrēd.
100	ealcar	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinat	ion and/or ir	vestigation, in my	opinion, de	eath occurr	ed at the time,	date and pla	ice, and due t	o the cause(s)
2		29b. Signature and title of certifier					nse number				igned (Month,	
		Jan 1	, MD			DO	0600	052		09/0	6/200	6
		30. Name and addr. ss of person who	completed cause of d	eath (Item	23а) (Турв.	Print)	.I. 7	1000	D. 11	יי מיי	17.2 11	772:
		Carlos Weiss  31. Date filed (Month, Day, Year)	32 Booist	ar's Signa	n prve	MFL SU	178 /	000	DUTO.	My 2	1024-	-4174
Statç istra	1.8	31. Date filed (Month, Day, Year)  SEP 0 8 200	Z. negistra	ar a arginal	Both	200						
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		•		ite of Marylan	d / Depa	artmei		ealth and N	Mental Hyg	7		28505
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  Elaine Vivian White					-	2. Date of Dear			3. Time of Death 5:48a M
	/Medic Examin	al	4a. Facility Name (If not institution, give street in 1430 Union Ave Ap				Town, or taltin	ocation of Death		4c. County of Death Baltimore		
	Funeral Director		5. Sociat Security Number 213-64-7983 6. Sex	7. Age (In yrs. 51	last birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birth	-1954	9. Birthp Coun	lace (State or Foreign try) MD
	Maryland I-f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Baltimo		y, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes ※XXNo
	th with the 23a or 28s	Funeral Director	10e. Street and Number 1430 Union Ave Ap	t A		10f. Z	p Code	21211	1	10g. Citizen of What Country? USA		
036	within 72 hours after death with the Maryland ene. than 'naturel', or iteme 23e or 28e-f ehow fra Madical Examinar maal be notified at	þ	An	as Decedent Ever in U. med Forces? ] Yes 2 [] No /es, Give ar or Dates:		Was Dece If Yes, spo 1 TYes		panic Origin? (Sp. Mexican, Puerto Specify:	acify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			etc.
Baltimore, Maryland 21215-0036	Peges 1 and 2 should be filed nent of Health and Mental Hygi ant: If Item 27 is marked other ury or other traumatic event, I	Completed	15. Decedent's Education (Specify only highest grade composition)  Elementary/Secondary (0-12)  Control 12	oleted) tlege (1-4or 5+)	1	dent's Usi kind of w DO NOT		ion ring most of wor	king	16b. Kind of Business/Industry  OWn Home		
/land		To Be C	17. Father's Name (First, Middle, Last) Russel Arthur Whi	te			1		ne (First, Middle, Maiden Surname) ne Vivan Ivins			
Man			19a. Informant's Name/Relationship (Type, Pr. Brian White/son	int)						nber, City or Town, State, Zip Code) more MD 21211		
imore,			a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory 9/9/06  Beltsville, MD									
Balt	permit. Pe Depertmen Important: any injury once.		21. Signature of Funerat Service Licensee  22. Name and Address of Facility CAFA  8717 Green Pastures Dr. Bal							2 ltimo	1286 re, MD	
760,	hysicien and hysicien and as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Se on each line.  Metusta  Due to (or as a conseq  Chrom  Due to (or as a conseq  Diabol  Due to (or as a conseq	tic ( uence of):  uence of):  les			•	ective		iease	Approximate Interval Between Onset and Death  8 mon/h
P.O. Box 68	The law requires thet the death certifica tte has been signed by the ettending ph lege 2 should be detached for use as the	Physician/Med	in the past 12 months?	res, outcome of pregna  Live birth 2   Feta  Pregnant at time of d  Unknown	I death 3	]Ectopic p ] Other (s	oregnancy pecify)				Date of delive	ry Day Year
	w requires thet been signed b should be deta	þ	Part II. Other significant conditions contributions Congestive Ho		-		cause giver	in Part I.	1 🗆 Ye	es 2□No	3 🗀 Prob	e cause of death? ably 4 Onknown
Vital Records,		e Completed	25. Was case referred to medical					26. Place of Dea	24a. Was a autops perform 1 Yes 2	med? 2. No	prior to condeath? 1 Yes	osy findings available inpletion of cause of
Division of V	g iš	ation: To B	examiner?  1	li: 1 □ Inpatient 2 □ 1. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of tnjury		OA Dther 28c. Injury a Work?	4 ☐ Nursing H	ome 5 Reside 28d. Describe ho	ence 6 🗆 C	(	)
Divis	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 Homicide	. Ptace of tnjury - At he building, etc. (Specif	y)							
	he Hosp n 24 hou he Fune pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 ar	To the best of my kno n the basis of examina nd manner stated.	wledge, death tion and/or in	n occurred vestigatio	at the time n, in my opi	, date and place, nion, death occur	and due to the cared at the time, d	ause(s) and a ate and place	manner as st e, and due to	ated. the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	2 1	1.	29	C. License	number 807	7 2	_	ned (Month, 1 7-0 C	Dey, Year)
	3		30. Name and address of person who complete Kavita Kalra MD 20	ed cause of death (Item 00 E 33rd			imar	> MD 3	1219			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2006	32 Renistrar's Signa	dure	Dall	Illor	e MD Z.	1210			

Derrick Woodhouse Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2006 28506 1. For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day August 17, 2006 **Medical Examiner** 1733 hrs Derrick Woodhouse 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of unk 5. Social Security Number unk 6. Sex **Funeral** 7. Age (In yrs. last birthday) oreign Months Days Hours Director 40 Country) Jan 14, 1966 Usual Residence of Decedent 10c. City, Town or Location É 10a. State 10b. County 10d Inside City Limits is 23a or 28a-f show e notified at once. MD X Yes 2 No Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code unk 10g Citizen of What Country? 349 Herring Court USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married unk White, etc. Yes "natural", ( 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify. Specify: black 4 2 or Dates.

15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet 21215-0036 unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) unk Be ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD O.C.M.E. lll Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation ( X Other Specify in state 21. Signature of Pineral Service Licer 22. Name and Address of Facility Ronald Director State Anatomy Board 655 W. baltimore Street Baltimore, MĎ 21201 ations that caused the death. Do not enter **Physician** the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and /Medical Choking due to blockage of airway by a foreign body Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and d ca XUNPENDED burial AMENDED Physician/Medi item#23a, PII, 27, 28a-f, per ME, g859, 9/13/06 TI Box 68760, IF FEMALE: phy: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u>. 23e Did tobacco use contribute to the cause of death? 2 Yes 2 V No 3 Probably 4 Unknown Narcotic intoxication Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? page ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medica 26 Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural 1 Yes 2 X No 5 Pending Director: 8/17/2006 5:00 pm subject choked 2 X Accident Investigation 28f Location (Street and Number or Rural Route Number City or Town State) 1600 Block Fast Uliver t. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) outside on city street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical

To the Hospital or Attending Physician: To the

one)

29b. Signature and title of certifie

Melissa Brassell, MD

31 Date filed (Month, Day, Year)

State Registrar

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

ML 30. Name and address of person who completed cause of death (Item 23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day Year)

August 18, 2006

State of Maryland / Department of Health and Mental Hygiene 28507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Clyde Wilkinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/20/1928 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 217-24-3975 Director Pennsylvania 78 Usual Residence of Decedent r 28a-f ahow 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Director Chase 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? r than "natural", or Itema 23a or the Medical Examiner must be 12815 Eastern Avenue 21027 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1946– 1948 2 □ No 1946– If Yes, Give Year or Dates: 1948 Btack, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2\(\overline{\text{V}}\overline{\text{No}}\) Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) 2 Salesman Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit ment of Health and Mental H tant: if Itam 27 is marked ott jury or other traumatic avan Earl Wilkinson Dorothy Kauffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alyce Mae Wilkinson (Wife) 12815 Eastern Avenue, Chase, Maryland 21027 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc 09/08/2006 Paltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) **Physician** arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physicien: The law requires that the death certificate be executed and burial-transit Due to (or as a consequence of): physician s the burial P.O. Box 68760. Completed by Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No 2 No certificete 1 Yes 1 Yes director, Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how intury occurred 28c. tnjury at Work? 1 Natural 5 Pending death. 1 Yes 2 No within 24 hours efter death To the Funeral Director:, completely filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of triury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitei 29a. Certifier 坑 🖄 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) D54725 of person who completed cause of death (Item 23a) (Type, Print) quare Drive JOSE Franklin 31. Date tiled (Month, Day, Year) State SEP 0 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17 perFH. C859.9/8/06, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 28508 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year SEPTEMBER OF 2006 8:10AM WHITE JAMES 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, O6 03 N/A Bon Secours
5. Social Security Number Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 □ F MD 52 54 214-58-7810 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Y□Yes 2□No Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 742 Linnard Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Becton Dickerson Co. Warehouseman na 12th grade 17. Father's Name (First, Middle, Last) White 18. Mother's Name (First, Middle, Maiden Sumame) Catherine B. Brice James Norman Whhite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 Athologate Lane Apt D, Balto, Md 21229 Kathleen B. Roane-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ↑ Burjal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Randallstown, Md 9/12/06 King Memorial Park 22. Name and Address of Facility
March F/H West 21. Synature of Funeral Service Licensee 21215 Ave, Baltimore, Md 4300 Wabash 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CAPCINAMATOSIS Immediate Cause (Final

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, signed by I cate has been sig , page 2 should b After this certificate has funeral director, page 2 within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

**Physician** 

/Medical

10a. State

MD

Director

Completed by Funeral

Be

ဂ္

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.

ant: if Item 27 te marked other then "naturel", or iteme 23e or 28e-f ehow ury or other traumatic event, I'm Medical Examinar must be notified at

Department of H
Important: If Ite
any injury or ot
once.

Physician /Medical

Baltimore, Maryland 21215-0036

disease or condition resulting in death)	Due to (or as a consequence of):		17401777	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  ARTERIOSCL  Due to (or as a consequence of):	EROTIC HEAR	T DIST	A5E
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
MALNUTE	NAL FAPLURE	underlying cause given in Part I.	1	
25. Was case referred to medical	21/10/0/3/3	26 Place of Dea	th (Check only one)	
	lospital: 1 1 npatient 2 ER/Outpati			6 ☐Other (Specify)
	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	
27. Manne_of Death  1	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	scolow no.	29c. License number  D 23300	ļ	Date signed (Month, Day, Year)  PTEMBER 06 2006
20 Name and address of person who co	ompleted cause of death (Item 23a) (Typ	De, Print) 130N 5EG		

BA27 P. ST.

BALTI MD. 21223

Registrar DHMH 17 Rev 1/2001

State

SUDHIR"

SEP 0 8 2006

31. Date filed (Month, Day, Year)

D.

32 Registrar's Signature

2000 W.

			1 - For State of N	Naryland / Dep Ce	ertificate of E		ental Hygier	2006	28509
	Physici	an	Decedent's Name (First, Middle, Last)	(2)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Expellity Name (If Not institution, give street and number	JOK.	4b. City, Town, or	Location of Death	)eptember	4c. County of De	
	LAGITIII		DON Secour Hos	Pital		more		N	/A
	Funeral Director		5. Social Security Number 6. Sex 7. AM 2 F	Age (In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Bri	nthplace (State or Foreign outtry) North Carolid
	land ow		Usual Residence of Decedent  10a. State / 10b. County	10c. City_Town or I	ocation				10d. Inside City Limits
	Ba-feh	ctor	Md N/A	JAIH.	more				1
	th with the	al Dire	1938 W. Mosher	treet	10f. Zip Code	217	10g.	Citizen of What C	ountry?
920	72 hours after death with the Maryland *natural; or iteme 23a or 28a-f ehow oldel Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Ves. Give Year or Date:	s? Mo	. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Am- Black, Whi Specify:	
21215-0036	- 19	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Dccupa re kind of work done d OO NOT use retired)	uring most of workir	16b	. Kind of Business	s/Industry
	filed within I Hygiene. other than "	Com	Elementary/Secondary (0/2) College (1-4c	(5+)	Long sh	orema		)teams	hip
land	thould be find Mental Humarked of	To Be	Bruce Wilkins			DellA	(First, Middle, Maid	of f	
Maryland	2 2 2		19a Informant's Name/Relationship (Type, Print)	Wise 33	ling Address (Street a.	nd Number or Rura	Route Number, Cit	y or Town tate,	Zin Code) Md
Baltimore,	Pages 1 and nent of Health int: if item 27 iry or other tr		20a. Method of Disposition  1	" King Me	ematory on other place	9-1:	2-06 RA	Location - City or	Frenz Md
Balti	permit. Pages Department of I Important: if its eny injury or o		21. Sign ture of Fune at Service Dicensee	5	Name and Addigs:	Han Ave	JA FUR	erul H	21217
	7		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not er				^	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	static N	on- Lux	all Cell	Lung	Cancer	S wanths
18	Examiner		Sequentially list conditions.				0		
1	d d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
,09289	icate be executed physician and the burial-transit		annutation in when the transfer	as a consequence of):					
9	rtificate ng phys as the	Aedical	d		_				
P.O. Box	the death certific y the attending p iched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			23d. Date of de Month	olivery Day Year		
	law requires that the death as been signed by the atte 2 should be detached for		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	n in Part I.			o the cause of death?
Division of Vital Records,	The la ete has page 2	Completed					24a. Was an autopsy performed 1 Tyes 2 2	2 prior to death?	utopsy findings available completion of cause of s 2  No
Z Z	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital:	itient 2 PER/Outpatie	ent 3 DOA Cthe	26. Place of Death	Check only one	6 ∏Other (Spe	acify)
o uc	ing fter		T Chatara S C I diding	njury 28b. Time Day Year) Injury	Work	at 2	8d. Describe how in		,
ivisio	ii or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, farm, s etc. (Specify)			8f. Location (Street City or Town, St		lural Route Number,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the ft	edical Ce	29a. Certifier 1 Certifying Physician: To the be (Check only 2 Madical Examiner: On the basis	st of my knowledge, dea of examination and/or i	ath occurred at the time investigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the within To the comple	Me	29b. Signatur and title of certifier  39 Name and address of person who completed cause of the complete (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Region (Complete (Month, Day, Year)	ı.D.	29c. License	number 5390	29d.	Date signed (Mon	th, Day, Year) 7, 2006
	5		39 Name and address of person who completed cause of Min (M. 2.) 9114	death (Item 23a) (Type Dickladelp	Print) Roa	d#208	- Baltin	wore, 1	ND21236
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	trar's Signature	als)		/		
16	The Company		CED II & TONO THE	12 0 0 P.					

DHMH 17 Rev 1/2001

Grady Wilkins, Sr.

06-06563 Darren Wilson Please Type or Print in Black Indelible Ink

ren Wilson	State of Maryland / Department of 1-For State Certificate of		Reg. No. 2006 28511							
Physician/	Registrar 1. Decedent's Name (First, Middle Last)	2. Date of D	Death 3. Time of Death							
dical Examine	The state of the s	Septem	aber 2, 2006 0545 hrs							
	Sinai Hospital	Baltimore City	N/A							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. 8. Date of	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)							
	Usual Residence of Decedent	PPK	( XV, 11134 11132							
d de an	10a. State 10b. County 10c. City, Town or Location Baltimore		1 10d. Inside City Limits  1 Yes 2 No							
0036 within 72 hours after death with the Maryland piene. ner than "natural", or items 23a or 28a-f show any Medical Examiner must be notified at once. ompleted by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
eath with the items 23a or ust be notifie	0 10 17 / 000 1111	Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian, Black,							
or items 23 must be no	1 Never Married 2 Married Armed Forces? If Yes	s, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.							
2 hours after de "natural", or Examiner mu	15. Decedent's Education (Specific cells highest grade completed). 150 Decedent's	Yes 2 No specify: s Usual Decupation (Give kind of work done	Specify: DIACK							
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner o Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during mo	st of working life. DO NOT use retired)	Boul							
215-0036 be filed within Intal Hygiene rked other than ent, the Medics Be Compli	17, Feyher's Name (First, Middle, Last)	18.Mother Name (First, Midd)	o, Maiden Surname)							
21215-00 hould be filed wit and Mental Hygien is marked other utic event, the Mi	Dingleton VVi/SON	Address (Steet and Number of Brist Book )	STOSS							
MD 21 d 2 should th and Me n 27 is ma numatic ex	NARY Wilson (Mother) 2424	Address (Street and Number of Ryral Route I FRUIT OF AVE	BAItO Md 21215							
of Heal	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State rematory or other		20c. Location - City or Town, State							
Baltimore permit Pages 1s Department of He Important: If it injury or other t	4 Donation 5 Other Specify: VVCOd Au. 22-Na. Signature of Funeral Service Licensee 22-Na.	ing and Address of Sacilly (1) TO F	uneral Home							
	23 Ball Electric V. Williams 31	40 N. Futton Ave TBA	1timore, Md 21207							
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds									
Examiner	or condition resulting in death)  Due to (or as a consequence of):	, - 444								
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
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50, te be executed lysician and suburial - transit	d. UNPENDED AMENDED									
ficate be g physic the bur	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery							
Division of Vital Records, P.O. Box 68760, the luspital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The function of the functio	past 12 months?  1	al death 3 Ectopic pregnancy er (Specify)	Month Day Year							
D. Bc tr the dee by the a ached fo	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I. 23e. Di	d tobacco use contribute to the cause of death?							
S, P.O.  Jires that the signed by defeach		1 🗍	Yes 2 No 3 Probably 4 Unknown							
of Vital Records, ng Physician: The law require- Wher this certificate has been sig- meral director, page 2 should be n: To Be Completed			as an 24b. Were autopsy findings available prior to completion of cause of death?							
I Rec n: The tificate or, page	25. Was case referred to medical	1 Ye 26 Place of Death (Check only one)								
Vital hysician this cert it directo	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 FR/Outpatient	3 DOA Other Nursing Home 5								
nding Ph th : After t e funeral	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month Day Year)  Sep 2, 2005 av Year)  0500 hrs	jury 28c. Injury at Work? 28d. Descri 1 Yes 2 ✓ No Subject S	be how injury occurred hot							
Division o spital or Attending bours after death neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office building, etc. 28f. Locatio	n (Street and Number or Rural Route Number, City							
ospital hours a uneral I ly filled		3500 Luc	n, State) ille Avenue, Baltimore City, Md.							
Division  To the Hospital or Attendity within 24 hours after death. To the Funeral Director: / completely filled in by the filled in by the filled in by the filled in the	20d Certifier 1   Certifying Physician: To the best of my knowledge, death occurred (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation and manner stated.									
W S - % -	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
0-	130. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	September 3, 2006							
9	Pamela Southall, MD Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21201								
State Registra	O O O O O O O O O O O O O O O O O	W. Carlotte								

State of Maryland / Department of Health and Mental Hygiene 2006 285 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 Carlyn Eva Woerner August 29, 0400 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. Min. North, Day, Year)

Months Days Hours Min. Jan. 20, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2□F Yrs. 1920 Maryland 86 215-01-9242 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County il Hygiene. other then "natural", or iteme 23a or 28a-f ehow vent, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Harford Bel Air Md. 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number U.S.A. 21014 758 Henderson Road Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) manufacturing factory worker 2 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Heelth and Mental Hy important: if item 27 is marked oth eny liqury or other traumatic event gone. Edna North William Hands 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 758 Henderson Road, Bel Air, Md. 21014 Mark Woerner/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Nat'l Cem. 9/1/2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Sever neumonia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 - Homicide ò Tip Certifying Physician: To the best of my knowledge death occurred at the time, date and clace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08/29/06 0062903 mpleted cause of death (Item 23a) (Type, Print) 30. Name and a Union Ave Hayre De Grace ,MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2008 Registrar

06-06661 David Wright

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		Redistrar	ate of Death	Reg.	No. 2006 2851
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) David Wright		Date of Death     Month Date     September 5	5, 2006 1749 nrs
		Facility Name (if not institution, give street and number)     Johns Hopkins - Bayview	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death
Funeral Director		5. Social Security Number 043-36-3894 6. Sex 7. Age (In yrs. last bin 60	thday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) CT
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County MD Baltimore Owin  10c. City, Town Owin  10c. Street and Number 4602 Spring Water Court, Apt G  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  17. Father's Name (First, Middle, Last) Wilbert D. Wright  19a. Informant's Name/Relationship (Type, Print) David Wright Jr. / Son  20a. Method of Disposition 20a. Method of Disposition 20b. Place crematics and Paramovel from State and Courty Town 20c. Method of Disposition 20b. Place crematics and Paramovel from State and Courty Town 20c. Method of Disposition 20b. Place crematics and Paramovel from State and Courty Town 20c. Method of Disposition 20b. Place crematics and Courty Town 20c. Method of Disposition 20b. Place crematics and Courty Town 20c. Method of Disposition 20c. Place crematics and Courty Town 20c. Method of Disposition 20c. Place crematics and Courty Town 20c. Method of Disposition 20c. Place crematics and Courty Town 20c. Method of Disposition 20c. Place crematics and Courty Town 20c. Place crematics and Courty Town 20c. Method of Disposition 20c. Place crematics and Courty Town 20c. Place crematics and Court	or Location  Ings Mills  10f. Zip Code 21117  13. Was Decedent of Hispanic Origin? (Sing Mys.)  1 Yes, specify Cuban, Mexican, Puerton Mexican	pecify Yes or No-Rican, etc.)  work done red)  for (First, Middle, Maio d Gibson Rural Route Number Baltimor Date 20/11/06	Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc. Specify:  Black  Sb. Kind of Business/Industry  Trucking  den Sumame)  1. City or Town, State, Zip Code)  1. City or Town, State, Zip Code)
M ଞୁଁ ଧିଆଁ ଆଧି Physician /Medical Sxaminer	ner	23a. Part I. Enter the disease, of complications that caused the death. Do not failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  a. Hy entersive cardio Due to (or as a consequence of):  b. Due to (or as a consequence of):		altimore MD	21230
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal - transit	Medical Certification: To Be Completed by Physician/Medical Examin	Second composition   Contributing to death but not resulting to death but	2 Fetal death 3 Ectopic pregna 5 Other (Specify)  g in the underlying cause given in Part I.  26 Place of Death (Check utpatient 3 DOA Other Nursin Time of Injury 28c. Injury at Work?  1 Yes 2 No arm, street, factory, office building, etc.	23e. Did tobac  1 Yes 2  24a. Was an autopsy performer  1 Yes 2  25d. Describe how  28f. Location (Street or Town, State)  due to the cause(s) at the time, date and	No 1 Yes 2 No  sidence 6 Other:  injury occurred  et and Number or Rural Route Number, City  and manner as started.
St Regist	ate	31. Date filed (Most Pay, Year) 2006 32. Igistrar's Signatur	Societi)		

			1 - For State Registrar		aryland / De	epartmen Pertificat			and Me	_	giene Reg. No	2006	28513
	Physici /Medic		1. Decedent's Name (First, Middle, Last Howard C. White	")						2. Date of De Month PTEMBI		72. 2006	3. Time of Death 4: 29 F M
	Examir		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical	Center	4b. City,	Town, or	Location o	of Death	n		County of Death	imore
	Funeral Director			7. Ag AM 2□F	e (In yrs. last birtho 79 Yr	Months		If Under a	Min.	8. Date of Bir (Month, Da Feb	y, Year)		place (State or Foreign ntry) ryland
	e Maryland 3e-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	e County	10c. City, Town of Timoniu								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	Funeral Director	10e. Street and Number 18 Hathaway Road			10f. Zip 210						izen of What Cou ced State	
036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if item 27 ie marked other than "naturat", or iteme 23e or 28e-f ehow importent: if item 27 ie marked other than "naturat", or iteme 23e or 28e-f ehow application of the frequent in the Medical Execution must be notified at ADGE.	<u>م</u>	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 A Yes 2 If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\sum Yes\)		spanic Origin, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	)-	14. Race - Ameri Black, White Specify: Whi	etc.
21215-0036	in 72 ho n "natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(6	ecedent's Usu Give kind of wo	al Occupa ork done di se retired)	tion uring most	t of workin	g	16b. K	ind of Business/Ir	ndustry
1212	filed within Hygiene. other than "	Com	Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	College (1-4ors		itoria	l Ser	vices	S		AME		
Maryland	should be find Mental Hermarked of	To Be	Clarence Charles	White						<i>(First, Middl</i> e 1a Whit		Sumame)	
Mary	d 2 sho th and h t7 ie ma		19a. Informant's Name/Relationship (7) Mr. Bryan White (	•		-	•					or Town, State, Zi Land, 211	,
Baltimore,	Pages 1 end nent of Heelth ent: if item 27 ury or other to		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Place of D	isposition (Na crematory or	me of other place	)		ate	20c. L	ocation - City or T	
Balt	permit. Depertrimports any inju		21. Signature of Funeral Service Licens	Legun		2325 Y	ork R	coad,	Time	nium M	laryl	Crematic	on Ctr. P.A
	Physician /Medical		23a. Part1. Enter the diseas and composition of heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. STROKE			de of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner		1		a consequence of)								
8760,	be executed ician and buriai-transit	lical Examiner	Sequentially list conditions, and list is any leading to annualists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
P.O. Box 687	tha death certificate be executed y the ettending physician and tched for use as tha burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal death	3 □Ectopic p 5 □ Other (s <sub>f</sub>						23d. Date of deliv	rery Day Year
	law requires thet tha de as been signed by the o 2 should be detached	ed by PI	Part II. Other significant conditions co	entributing to death t	out not resulting in the	ne underlying o	cause give	n in Part I.			tobacco ( Yes 2		the cause of death? bably 4 Unknown
al Reco	The lar ste has paga 2								·	24a. Was auto perfo 1 🗌 Yes		prior to co	opsy findings available ompletion of cause of
f Vit	Physician: r this certificatal director,	To Be	25. Was case referred to medical examiner? 1  Yes 2 No	Hospital: 1 Inpatio	ent 2 ☐ ER/Outp	atient 3 D	Othe			Check only		6 ☐Other (Speci	fy)
Division of Vital Records,	Attending in death.  ector: After by the funer	Certification;	27. Manner of Death  1 Naturat  2 Accident  3 Suicide  4 Homicide	28e. Place of in	y Year) 28b. Tin Inju jury - At home, farm tc. (Specify)	М		at ? ′es 2 □ l	No	8d. Describe	Street ar	nd Number or Rur	al Route Number,
Ö	To the Hospital or within 24 hours efta To the Funeral Dircompletaly filled in I	Medical Cert	29a. Certifier 12 Certifying Phy	vsician: To the best iner: On the basis of and manner st	of my knowledge, of examination and/	death occurred	at the tim	e, date an	d place, a	City or To	cause/s	) and manner as	stated. to the cause(s)
<b>\</b>	To the Within To the comple	Me	29b. Signature and title of centiler	2	/		c. License				29d. Da	te signed (Month,	Day, Year)
	110		30. Name and address of person who o	completed cause of	(L bars) death (Item 23a) (Tr		D 46	356		<	5ep	tember	02,2006
	V/ '		KHAROW TABASSI 31. Date filed (Month, Day, Year)	M.D. 76	OIL DOLD	ם החד	VE T	OWNS	1,NO	1ARYLA	QNE	21204	
	Sta Regist			2006	ars signature	front							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16b, 20b per fh 9859, 9-8-06 vt. State of Maryland / Department of Health and Mental Hygien 2006

28514 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Williams **Physician** 08 5:00 AM 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Flectwood If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 241 42 6515 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 X M 2 ☐ F 73 10/24/1932 Director NC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Execution must be notified at Baltimore 1 X Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3036 or Iteme 23a Fleetwood 21214 Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☑ No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Black 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) WORKER Beth Steel NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Addins Williams Kobert Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheara Are Baltimore daughter) 3036 Fleetwood MD SISIL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages to Department of Himportent: If its eny injury or ot once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Baltimore Suc 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT 09/06/2006 23 Name and Address of Eachlite Funeral SISY Balto North Pike 21. Signature of Funeral Service Licensee North Pike, Baltimore MD 21229 reen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ninute /Medical Due to (or/as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 Unknown 1 ☐ Yes 2 ☐ No certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy Yes 2 1 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 2 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Magner of Death 28b. Time of Natural Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 3 (Type, P 32. Redistrar's Signature State SEP 0 8 2006 Registrar

Please Type or Print in Black Indelible lake Ensure All Copies Are Legible.
AMEND TEEH/8, II, per INF., 6859, 9/11/06, ws
State of Maryland / Department of Health and Mental Hygiene 2006 28515 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ()9 **Physician** 02 2006 4:50 PM George Wright /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore City n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 F **Funeral** Days Months Hours 231-30-9287 74 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or Iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notitied at tX☐Yes 2☐No Director MD n/a Baltimore City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 5434 Price Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Never Married 2 Married Specify: Black 5-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12th unknown steel worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Janie Lee Hunt Lawson Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Betty L. Wright / Wife 5434 Price Avenue; Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It eny Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2006 Louden Park Baltimore City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. Jones 638 N. Gilmor Steeet; Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pancuatro /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnanl at time of death 5 Other (specify) P.0 ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide thin 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one)

State Registrar

2

MARON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CHAMURS

wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6601 N. Charles

32 Registrar's Signature

29c. License number

81

58303

Branne 000 21204

29d. Date signed (Month, Day, Year)

September 3 2006

State of Maryland / Department of Health and Mental Hygien 2006

2	O		1	-
_	O	5	1	O

		•	1 - State Registrar	•	Ce	rtificate of	Death	•	Reg. N	<b>2000</b>	200	, 10
	7.	* 1	1. Decedent's Name (First, Middle, La	st)		2. Date of I Month			ath		3. Time o	of Death
	Physici /Medic	- 7	John Tho	mas Armstrong				August		ay Year 2006	5:00	A M
	Examin	4	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Location of Death				c. County of Death		_
		4	St. Mary's Nursing (	Center		Leonard	town		S	t. Mary's		
-	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday,	ff Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	y, Year		place (State untry)	or Foreign
6	Director		718-03-2040 Usual Residence of Decedent		87 Yrs.			May 23,	1919	Mar	yland	
	land		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside C	City Limits
	Mary	ţ	Maryland St. Mary	's	Avenue						1 🗌 Yes	2 <b>∑</b> No
	r 28g	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cor	intry?	
	738 o	0	38340 Sugar Hole Ro	ad		20609				USA		
	deal	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No	)-	14. Race - Amer		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event. I'm Medical Evarifical must be notified at ance.	þ	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 1 Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		o riican, etc.)		Black, White	ack	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra		(Give	edent's Usual Occup kind of work done	during most of wor	kina	16b.	Kind of Business/l	ndustry	
7	ithin se	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	9				
7	led w lygier her ti		8		Labor	rer	40.14.15.4.11			nstruction		
anc	half H	Be	17. Father's Name (First, Middle, Last	,			18. Mother's Nan Annie Cu		, Maide	in Sumame)		
Ž	d Me d Me mark matic	ို	'Thomas Armstrong  19a. Informant's Name/Relationship (	Type Print!	10h Maili	ing Address (Street	1		or City	or Town State 7	in Cada)	
Σa	d 2 s th an trau		Frances Lucinda Am			) Sugar Hole					) (Jode)	
ē,	Heal Heal tem 2		20a. Method of Disposition		0b. Place of Disp	osition (Name of	- 1	Date		Location - City or 1	own, State	
Baltimore,	tment of tent: If I tent: If I		1 № Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	Sacred Hea	art Cemeter	1, 2	ember 006	Bus	shwood, Mar	yland	
Bai	Depar Depar Impor any ir		21. Signature of Funeral Service Lice	Haden (	) M	2. Name and Address attingley—Go. Box 270	ess of Facility ardiner Fun Leonardto	eral Home wn, Maryl	P.	A 20650		
٠			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the							Approxima Interval Be	tween
	Physician	11.	Immediate Cause (Final disease or condition	Ke	a nak	sut.	alus	1			Poset and	Death
4	/Medical		resulting in death)	Due to (or as a co	(sequence of):	J					1	A
	Examiner		Sequentially list conditions	·	iO.P	ND					YX	1
	sit ad	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):	~				V			
	ertificate be executed ling physician and e as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):						0	
68760,	be e sician buria											
687	ficate phys s the	Medical		_ d								
	nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr						23d. Date of defin	/erv	
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□ 4□Pregnant at time		<pre>Ectopic pregnanc</pre> Other (specify)	у			Month	-	Year
O.	by the	hys	9 Unknown	9□ Unknown								
Ś	The law requires that the death cate has been signed by the attendage 2 should be detached for us	by Physician/	Part II. Other significant conditions	contributing to death but no	t resulting in the t	underlying cause giv	ven in Part I.	23e. Did	obacco	use contribute to	the cause of	death?
ord	en si	bet	1/184	Mahr	Cane	101		1,22	Yes :	2 ☑ No 3 ☐ Pro	bably 4	Unknown
ecc	e lawr has be je 2 sh	Completed		32				24a. Was		24b. Were aut	opsy findings ompletion of c	available
m m	The ate h page	PO	,					perfe	ormed?	death?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
/ita	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea		оле)			
7	Phyalcian: rthis certifica ral director, p	ို	1 ☐ Yes 2 ₺ No	Hospital: 1 Inpatient	2 ER/Outpatie		4 M Nursing n	ome 5 Res	dence	6 ☐Other (Spec	fy)	
Ĕ	ding P h. After 1 funera	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wo		28d. Describe	how int	ury occurred		
Sic	Attending in death. ector: After by the fune	cat	2 Accident investigatio		A45		Yes 2 No	001	· O4		15	
Division of Vital Records,	al or Attendation of Director:	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	reet, factory, office		City or To		and Number or Rui te)	ai Houle Nun	nber,
	To the Hospital or Attending Phyalcian: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Pt	nysician: To the best of my niner: On the basis of exa and anner stated.	y knowledge, dea mination and/or ir	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time.	cause( date ar	s) and manner as nd place, and due	stated. to the cause(	(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	A allies stated.		29c. Licens	se number		29d. D	ate signed (Month	Day, Year)	
1	- s - ŏ		la 1	Hanks	= M	NI	D64	19	X	7-287-	06	
1	M		30. Name and address (1 erson who	plets cause of death	(Item 23a) (Tune	Print	, , , ,	· · /	O	0.0	-0	
	170		James Patri/ck Jarbos		0310 11	n Road, Hol	lwood Mar	vland 206	36			
i e	Sta	te	31. Date filed (Month, Day, Year)		Signature	ade)	-,	, 111111 200	<u>.</u>			
o.	Registr	ar	AUU & J L	UUU LANGE	1	-						

State of Maryland / Department of Health and Mental Hygiene Reg. N. 2006 28517 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 28, Bertha Lee Adams August 2006 4:15 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 45857 Meadow Lark Drive St. Mary's Great Mills If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Yrs. 83 Director 409-26-8330 26,1923 | Mississippi Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 XNo Directo Maryland St. Mary's Great Mills 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ Itema 23a 45857 Meadow Lark Drive 20634 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced neturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ue filed w...
Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Worker Federal Government permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If item 27 is marked oth eny injury or other treumatic event 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Phillip McCrary 2 Frances Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlesetta Brown/ Daughter 45857 Meadow Lark Drive, Great Mills, MD 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Tennessee Vet. 9-2-2006 Memphis Tennessee 21. Signature of Funeral South Incensee
Edward N. Brinsfield, Ir. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis /Medical Due to (a as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit certificate be executed Diabetes Due to (or as a consequence of): Box 68760 ettending physicien by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown ģ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this Director: After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mr. nth, Day, Year) 8 30 06. D 0032651 Rita 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L Rx ington Paul m& 20653
RITH B. JHHIBRI. 22335. 32. A gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

# Uller, Barland Benneth Baltimore, Maryland 21215-0036

			1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death		2006	28518
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Va	3. Time of Death
	Physici		BARBARA B.	ALLEN		AUGUST	28 7000	710 PM
	/Medi Examir		4a. Facility Name (If not institution, give s	reet and number)	4b. City, Town, or Location of Dea	7	4c. County of Death	
	LXdiiii		DOCTORS CMMUN	ITY HOSPIT AT,	8118GOOD LUCK	RD.	PRINCES O	FODCEC
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs	S. B Date of Birth	9 Richo	lace (State or Foreign
	Director		040-48-3190	M 2√F 53 Yrs	Months Days Hours Min	3-14-	53	**
	ס		Usual Residence of Decedent				S004	H CAROLIN
	72 hours after death with the Maryland neturel', or theme 23a or 28e-f ehow disal Evantraer must be notified at		10a. State 10b. County	10c. City, Town o	r Location		1	0d. Inside City Limits
	Mar Mar	to	MD PRINCES	GEORGES LANH	MA			XXYes 2 □ No
	r 28g	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Coun	try?
	3a o	0	6505 MIDDA DD	EVID	20706		77.0.3	
	Tie 2	Funeral	6505 MIDRA DR	2. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin?	Specify Yes or No-	USA 14. Race - Americ	an Indian,
	ther c	μ̈	1 Never Married 25 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White,	etc.
3	Irs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BLA	CK
21215-0036	2 hou	Ped	15. Decedent's Educ	ation 16a. De	ecedent's Usual Occupation	16	6b. Kind of Business/Inc	
73	in 7	Completed	(Specify only highest grade	'lit	tive kind of work done during most of wo e. DO NOT use retired)	orking		,
12	within iene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKED			
	Hygid Hygid Sther		17. Father's Name (First, Middle, Last)	7042	HOMEMAKER 18. Mother's Na	ime (First, Middle, Ma	uiden Surname)	
a	Mental Mental arked o	To Be	ISIAH BENNET	DEC	OUEE	N E. M	URRAY DE	·C
<u></u>	and Marie mari	-	19a, Informant's Name/Relationship (Typ		ailing Address (Street and Number or F			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Health and Mental Hyglene. Item 27 is marked other then "neturet", or items 23s or 28s-1 show other treumatic event. It is Medical Examinar must be notified at							
	1 and Health em 27		JOE ALLEN  20a. Method of Disposition	20b. Place of Di	5 MIDRA DR. LAI		YLAND 207 c. Location - City or To	THE REAL PROPERTY AND ADDRESS OF THE PERSON
ō	00-		1√2 Burial 2 ☐ Cremation 3 ☐ Re	moval from State cemetery,	crematory`or other place)		or Location Only of To	wii, otato
Baltimore,			4 Donation 5 Other (Specify)		RT NAT.CEMET.9-	1-06B	EAUFORT, S	.C.
39	Departi Departi Import any inj		21. Signature of Funeral Service License	. /	22. Name and Address of Facility			
_	<b>₹</b> 0 = 4 d		Muara & Ly	1 I	IINUS FUNERAL H	OME ZZZN	QUEEN ST	.DOVER DE
	Physician but and physician and physician and physician and physician it is partial transit.	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (vr.as a consequence of):	ardromy,	pato	ly thy	Approximate Interval Between Onset and Death
	The law requires thet the death certifica Ne has been signed by the ettending ph age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
٥.	es the igned b	by P	Part II. Other significant conditions conf	ributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ğ	n sign	D D	S-E1Z	URES		1 ☐ Yes	2 No 3 ☐ Prob	ably 4 \textcal{Dunknown}
Records,	w requir been si should	Completed				24a, Was an	24b. Were autor	osy findings available
Re	The lay	Ë				autopsy performe	prior to con	npletion of cause of
	W						YNo 1 ☐ Yes	2□ No
Vital	certifice rector, p	o Be	25. Was case referred to medical examiner?	ospital:	Other	eath (Check only one)		
of	ding Physicien:  After this certifications of the director,	III i	1 Yes 2 No	28a. Dale of Injury 28b. Tim	tient 3 DOA 4 Nursing	Home 5 ☐ Residen	ce 6 Other (Specify	")
	ding F h. After funera	<u>6</u>	1 Natural 5 ☐ Pending	(Month, Day Year) Inju		200. Describe now	anjury occurred	
Division	tent fleath tor: the	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Discouling Albania		204		
<u>&gt;</u>	or Attenation of the T	ŧ	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	City or Town,	et and Number or Rura. State)	Houte Number,
	urs a		an our body		SANS SANSAN SANS			
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Afte completely filled in by the fune	edical	(Check only 2 Medical Examin	er: On the basis of examination and/o	eath occurred at the time, date and place r investigation, in my opinion, death occ	a, and dua to the causurred at the time, date	se(s) and marriet as st and place, and due to	the cause(s)
	the the	Med	One)	and manner stated.				-1
	7 v.i.		29b. Signature and title of contrier	1	29c. License number		I. Date signed (Month, I	Ay, rear)
	6		Moxaer-		200589	146	8/28/0	XUU6
	0		30. Name and address of person was con-	ppleted cause of death (Item 23a) (Ty	pe, Print)		01 1 1	
	My		Ivadenzda' 1	covalchuk	=, 14 B 8118 C	Sacd Luck	Ko, Lanhan	n, MD. 2006
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrats Signature	last 1		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bre

### Please Type or Print in Black Indelible Ink

enda Bullington		Sta - For State	te of Maryla	ind / Depa			Mental H		20	NE	2851
Physician		Registrar 1. Decedent's Name (First, Middle	Last)			2. Date of Deat	h		ne of Death		
ledical Examin	er	Brenda		Llington				Month August 16	Day Year , 2006		15 hrs
		4a. Facility Name (if not institution 10145 Campus Way S		mber)		4b City, Town, or L Largo	ocation of Dea	ath	4c. County of E Prince Ge		
Funeral		5 Social Security Number	S. Sex	7. Age (In yrs	last birthday)	If Under 1 Year	If Under 24H		th(MM/DD/YYYY)		
Director			1 M 2K F	48	Yrs	Months Days	Hours M	March	19,1958	Country)	Carolina
any	- 1-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loca	tion				10d	Inside City Limits
<b>≱</b>	اي	Md. P.G.								1 x	Yes 2 No
daryłand <b>28a-f show</b> <u>1 at once.</u>	Director	10e. Street and Number		القط ا	rgo	10f. Zip Code		11	0g. Citizen of What	Country?	
the N	اة	10145 Campus W	ay South			20774			U.S.A.		
JD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status  1 Never Married 2 X Mar		edent Ever in U prces?		as Decedent of Hisp es, specify Cuban,			- 14. Race - A White, e		dian, Black,
er deal	<b>-</b>		1 Yes	2 <sub>X</sub> No	1	Yes 2 X No	snecify:				
urs aft tural'	<u>۾</u>	15. Decedent's Education (Speci	or Dates:		16a. Decede	nt's Usual Occupation	on (Give kind o		16b. Kind of Busin	White ness/Industr	y
5 72 ho m "na	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)	during n	nost of working life.	DO NOT use re	etired)			
5-0036 Iled within 72 Hygiene J other than	ᇍ		6+		None				None		
15-( filed al Hyg ed oth rt, the	မ္မ	17. Father's Name (First, Middle, I				[1		me (First, Middle, Market) a Unknov	,		
ID 21215-00; should be filed within and Mental Hygiene 7 is marked other if mair event, the Med		Wilbert Bullin 19a Informant's Name/Relationsh			19b. Mailin	g Address (Street			nber, City or Town,	State, Zip C	ode)
T T Z Z Z Z		Robert Jackson				Campus W					
altimore, M rmit Pages I and 2 spartment of Health portant: If item 2 inry or other traun		20a Method of Disposition  1 Burial 2 X Cremation	3 Removal fr		Place of Dispo crematory or o	sition (Name of cent ther place)		Date	20c. Location - C		
Page ment or otl		4 Donation 5 Other Spe	ecify.	Ri		Pk Crem		29/06	Riverdal		l.
Baltimo permit Page Department Important: injury or otl	Ų	21. Signature of Funeral Service	icensee						en ins		
Physician	-	23a. Part I. Enter the disease, or o		aused the deat						App	roximate Interval
/Medical		failure. List only one cause of Immediate Cause (Final disease		one and f	entany1	intoxicatio	1			Bet	ween Onset and Death
LAAIIIIIGI		or condition resulting in death)	Due to (or as a	consequence	of):						
-	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence	of):						
	Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence	of):					-	
cuted	۱		d								
	dical	XUNPENDED	AMENDED	item#23a	a.27.28a-	f.perME.g859	9.9/13/06	5 TT			
6876C certificate nding phys	an/Me	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pre	gnancy	etal death 3	Ectopic preg		23d Date of de Month	elivery Day	Year
Box 6876C e death certificate the attending physe	Sic	past 12 months?  1 Yes 2 No 9 V Unk		nant at time of o		ther (Specify)			1		
O.O. BC that the degreed by the g	Phys	Part II. Other significant condition	a Ouku		resulting in the	underlying cause g	iven in Part I.	23e. Did to	obacco use contribu	ite to the ca	use of death?
P.C	2		· ·		•	, , ,		1 Yes	s 2 No 3	Probably	4 V Unknown
ords, w requir	ete							24a. Was autop			findings available tion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should to	Completed		_						rmed? dea	ath? Yes	2 No
Vital Reorgician: The his certificate director, page	Be C	25. Was case referred to medical examiner?					of Death (Che	ck only one)			
F Vit	١٩	1 Yes 2 No	-	Inpatient 2	ER/Outpatier				Residence 6		e
nding Ph	io ::	27. Manner of Death  1 Natural 5 Pend		h, Day,Year)	28b. Time of	1 V	y at Work? 'es 2 X No	1 .	how injury occurred		
r Attenuer death	ficat	2 Accident Inves	tigation 28e Plac	8/16/2006 ce of Injury - At		noon   — eet, factory, office b		unk 28f. Location (	Street and Number	or Rural Ro	ute Number, City
Divisal or At ours after deral Direct filled in by	Certification:		not be mined (Specify)	Found	l at resid	dence		Largo, N	D 10145 (	ampus	way South
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the									se(s) and manner a		- (-)
To the Hos within 24 h	Medical	one) 2 Medical Exam 29b Signature and title of certifie	and manner :	oi examination stated	and/or investig	29c License		ru at the time, date	and place, and due		
	-	in his of certifie	mid			O.C.			August 17, 2		ay, 10ai j
		30. Name and address of person	1	ise of death (Ite	em 23a)						-
R			nt Medical Exa			et, Baltimore, l	MD 21201				
Sta	ate	31. Date filed (Month, Day, Year)	3 R	egistrar's Signa	ature	<i>v</i> .		_			

		•	1 - State of Maryland Registrer	/ Department of He Certificate of L		ntal Hygien	21116	28520
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Mary Elizabeth Bo	oggs			8 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	4	C 1	h
			1416 East Old Philadelphia Road  5. Social Security Number 6. Sex 7. Age (In yrs. las	Elkton	If Under 24 Hrs. 8.	Date of Birth	Cecil	nplace (State or Foreign
	Funeral Director		212-22-7544	Yrs. Months Days	Hours Min.	(Month, Day, Year March 28, 1	) Co	unsylvania
	land wo			Town or Location				10d. Inside City Limits
	a-f sh	tor	Maryland Cecil Ell	kton				1 ☐ Yes 2 😿 No
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. C	itizen of What Co	untry?
	e 23e		1416 East Old Philadelphia Road	21921			nited St	
	iter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No	. 13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto Ric	an, etc.)	14. Race - Ame Black, White	
936	ral', or	ğ	3 ¼ Widowed 4 □ Divorced II Yes, Give X Year or Dates:	1 □ Yes 2 No	Specify:		Specify: Wh	ite
- 2	72 ho	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done di	uring most of working	16b.	Kind of Business/	Industry
21215-0036	within 72 hours after death with the Maryland ene. Then "natural" or iteme 28a or 28a-f show he Medical Exambrar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	lite. DO NOT use retired)  Homemaker			In Her (	lwn Home
0	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Name (F			WII Home
<u>ılan</u>	uld be Mental rikad tic ev	To B	John Jacob Burns		Pearl Ma	rie McCal	lister S	Sechrist
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene.  The Marylant: If them 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a		-		
ره د	1 and 1eaith 1m 27 thar ti		Luther C. Boggs, Jr./Son  20a. Method of Disposition  20b. Pla.	1416 East Old	Date	9 200 1	Elkton, ocation - City or	
Baltimore,	ages int of I t: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nort	metery, crematory or other place th_East_	Septem	iber		
ij	nit. Postme		4 Donation 5 Other (Specify)  21. Signatule of Funeral Service Licensee	nodist Cemetery			rtn East	, Maryland
ñ	Depermine permine perm		Donud S. Huke	Hicks Home 103 W. Stoo	for Funera ekton Stree	als, P.A. et, Elkto	n, Maryl	and 21921
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Churrost's	of liver				Onset and Death
	/Medical Examiner		Due to (or as a conseque	ence of):				
	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	arresty dec	5005 P			
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	af livery ance of):  2 rterry de proce of):  e heart:	faclure	2		
Ö,	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or a conseque					
8760,		dical	d. COPD					
9 X	certifi nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant				23d. Date of deli	verv
. Box	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	in the past 12 months?  1 Ves 2 DNo 4 Pregnant at time of dea				Month	Day Year
о. О.	at the	Phys	9 Unknown 9 Unknown					
Records,	Physicien: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	ρ	Part II. Other significant conditions contributing to death but not result	ling in the underlying cause give	n in Part I.	23e. Did tobacco		the cause of death?
O O	aw require s been sig 2 should b	Completed				24a. Was an	24b. Were au	topsy findings available
æ	The I	mo				autopsy performed? 1 ☐ Yes 2 Ø N	death?	completion of cause of
of Vital	cien: artific actor.	Be (	25. Was case referred to medical examiner?		26. Place of Death (C			
of o	Physi this c	٦.			4 Nursing Home	5 A esidence d. Describe how inju		ufy)
O	Attending in death.	tlon	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work	? 'es 2 □ No	2. Describe now in	иу осситей	
Division	Atter ector by the	Certification:	o □ o vite C Could not be	ne, farm, street, lactory, office	28f	. Location (Street a City or Town, Sta		ral Route Number,
۵	ital or rs efte al Dir led in	Cert	building, etc. (Specify)			Oily or Town, Sta	θ)	
	To the Hospital or Attending Physicien: The law within 24 butus effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	ledge, death occurred at the time on and/or investigation, in my op	e, date and place, and inion, death occurred	d due to the cause( at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License	number	29d. D	ate signed (Monti	n. Day, Year)
1	->-0		I gun car No M	, 20	4823	8	130/06	
	2		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)		/	/ 50	
	9		Jui-Chih Hsu, M.D., 223 West Mai	in Street, Elkt	on, Maryla	ınd 21921		
	Sta Registr		31. Date liled (Month, Day, Year) SEP 0 8 2006	Localio				
			100000000000000000000000000000000000000					

State of Maryland / Department of Health and Mental Hygien 2006 28521 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 8 27 2006 12:38 A Catherine W. Blose /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Atlantic General Hospital Worcester Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 🛣 F Yrs. 81 Director 320-20-3109 5/2<u>/1925</u> ILUsual Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow itam 27 la markad othar than "natural", or itams 23s. or 28a-f ahov othar traumatic evant, 1's Medical Examinar must be rollified at 1 ☐ Yes 2x No Director Ocean Pines Worcester 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1729 Carrollton Lane 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) parmit. Pages 1 and 2 should ba filed within 72 hours after to Dapartmant of Health and Mantal Hygiene. If the Triam 27 la markad othar than "natural", or than any injury or othar traumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Michael Willkie Mary Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John M. Blose (son) 5461 Shady Grove Terrace, Memphis, TN 38120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2006 1 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery Memphis, TN 22. Name and Address of Facility 21. Signature of Euneral Service Licensee The Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760, 8/27/2006 attanding physician an/Medical Box ( 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown Des 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. غ/ه؟ Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this cartificata has 1 Yes 2 LNO il or Attending Physician: after daath, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred uneral 27. Manner of Death 28b. Time of Certification: Division of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours To the Funaral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53612 8/27/06 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9733 Healthway Dr Berlin, MO K Baier Andrea 31. Date filed (Month, Day, Year) SEP 0 8 2 Registrar's Signature State 0 8 2006 Registrar

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atherine

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Rag. N2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FLLEN BLOOM Day DOROTHY **Physician** September 3, 2006 8:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Adonths | Days | Hours | Min. | Nov. 20, 1 Citizens Care & Rehab Center Frederick County 5 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2X F 84 Director 085-20-9161 1921 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Manical Experience must be notified at Maryland Carroll County 1 Yes 2 No Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Kings Court 21787 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7/th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) hairdresser hair care 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emerson Smith Sarah Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Rebecca Brown / daughter 1 Kings Court Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Iment of P 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Sept. 5 ö permit. Page Department of Important: If any injury or once. Smithsburg Crematorium \*4 □Donation 5 □ Other (Specify) Smithsburg, Maryland 2006 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 Iun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final then scleritic Cardinvercular disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician eq Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. 27. Manner of Death Certification: or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a Decertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal the 29c. License number 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier D0031058 9-5-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashe 10200 Coppermine Rd P.O. Box 4, Wordsboro, MD 21798 14 31. Date filed (Month, Day, Year) gistrar's Signature State SEP 08 2006 Registrar

		1	For 'State Registrar	State of Maryland		artment of H tificate of L			giene eg. No 2006	28523
- Sec. 1	ysicia Jedic	ın	1. Decedent's Name (First, Middle, Last, NAN CY		BR	ENGS		2. Date of Dea Month CEPTEM	Dav Year	3. Time of Death 6 06224 M
Ex	amine	er '	THE JOHNS HOPK	WS HOSPITAL		4b. City, Town, or BALTIMO		TY	4c. County of Death	nplace (State or Foreign
Fun Dire	_		5. Social Security Number 6. Sec. 219–48–8654	7. Age (In yrs. lass	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Mar 18,	1947 Wa	shington DC
Maryland 1 • how	in Lat		10a. State 10b. County Maryland Frederi	.ck		cation Market				10d. Inside City Limits 1 ☐ Yes 2 XNo
with the A	De notifi	គ	10e. Street and Number 6530 North Shore	Way		10f. Zip Code	21774	1	10g. Citizen of What Cor	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or thems 23s or 28s-1 show	Samuer mus	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036 3d within 72 hours afi giene. er then "naturel; or	ne Mudical E	Completed	15. Decedent's Edu (Specify only highest grad		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired nistrativ	during most of world )		16b. Kind of Business/I	ndustry Transportat
and 2 d be filed antal Hygie	c event, i	Be	17. Father's Name (First, Middle, Last) Louis M	]	Royer			e (First, Middle,	Maiden Sumame) Armstr	4
Maryland of 2 should be file lith and Mental Hy 27 16 marked oth	traumatic	ဂ္	19a. Informant's Name/Relationship (T) Raymond A. Brengs						r, City or Town, State, 2 Maryland 2	
Baltimore, N permit. Pages 1 and Department of Health mportant: If Item 27	ry or other		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	20b. Plac cem	e of Dispo	osition (Name of matory or other plac Cemetery	e)	Date	20c. Location - City or Catlett, V	Fown, State
Baltimo	any Inju		21. Signature of Funeral Service Licens			Neme and Address Keeney & 06 E Chur	Basford Ch Str F	P.A. Fur rederick	neral Home k, MD 21701	
Physic			23a. Part 1. Enter the disease, or comp shock, or heart ailure. List only o Immediate Cause (Final disease or condition resutting in death)	lications that caused the death. ne cause on each line.	Do not ent					Approximate Interval Between Onset and Death
/Med Exam	iner		Sequentially list conditions,	Due to (or as a consequent						
. Box 68760, death certificate be executed e attending physician and	s the burial-transit	i Examiner	Cause (Disease or injury	Due to (or as a consequence.  Due to (or as a consequence)						
K 687( entificate to ling physic	e as the b	Medica	IF FEMALE:	d						
P.O. Box hat the death cert d by the attendin	detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3[	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P. quires that n signed by	. 9	by	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to es 2 No 3 Pro	the cause of death?
Re The la	page 2 should b	Completed							med2 prior to death?	topsy findings available completion of cause of 2 No
of Vital F Physician: Th	rector	Be	25. Was case referred to medical examiner?	Hospital: 1 Minpatient 2 □ EF	20.	nt 3 DOA Cth	0.00	th (Check only o		
on of	funeral	ilon: To	1 Yes 2 YNo  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		8b. Time o	of 28c. Injury	4 C Harsing H		lence 6 Other (Speciow injury occurred	city)
or Atten	in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st			28f. Location (S City or Tow	Street and Number or Ru vn, State)	ral Route Number,
Hospita 4 hours	9 ×	edical C		ysician: To the best of my knowl iner: On the basis of examinatio and manner stated.						
To the within 2	completely	Me	29b. Signature and little of certifier	( MD		29c. Licens	e number S-00 (		29d. Date signed (Monti	
01			30. Name and address of person who c	completed cause of death (Item 2	(Type)				•	
R	Sta egistr		31. Date filed (Month, Day, Year) SEP 0 8 20	ompleted cause of death (Item 2  OHL  32. Fegistrar's Signatu	re K	book		•		

		•	For State Registrer		State of	Marylar		artment o			lental Hyg	jiene leg. N2 0	06	28524
			1. Decedent's Name (First, Mic	dle, Last)							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Helen	Delo	res	Ве	11				Aug. 24			5:45pm M
	Examin		4a. Facility Name (If not institut	ion, give st	treet and num	iber)		4b. City, Tov	vn, or Local	tion of Death		4c. Cour	ity of Death	_
			Washington Ad			~		Takoma					gomery	
	Funeral		5. Social Security Number	6. Sex	M 2CXF		. last birthday)	If Under 1 Y Months D	ays Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State or Foreign
	Director		577-56-5518		423	64	Yrs.				Oct. 2	7,1941	Wash	1. D.C.
	and and		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. C	ity, Town or Lo	ocation					1	Od. Inside City Limits
	Manyi 1 • ho	ō	Md. Mont	gomer	***	Wh	eaton							Y Yes 2 □ No
	286-	Director	10e. Street and Number	30mer	у	WII	eaton	10f. Zip Co	de			10g. Citizen o	f What Cour	ntry?
	3a or	0	3410 Embry St	reet				209	02			U.S.A		
	ours after death with the Marylan el', or iteme 23a or 28e-f e bow Exprintment be multied at	Funeral	11. Marital Status		2. Was Dece		J.S. 13.	Was Decedent	of Hispanie	c Origin? (Sp	ecify Yes or No-		ace · Americ	
ω	or Ite	F	1 Never Married 2 ☑ M	arried	Armed For	2X No		If Yes, specify			Rican, etc.)		lack, White,	
Ö	rel', c	þ	3 Widowed 4 Divorc	be	If Yes, Give Year or Da	etes:		1 ☐ Yes 2 <b>ॉ</b> ☐	INO Spe	ecity:		Spec	Blac	k
21215-0036	within 72 hours after death with the Maryland liene. Then "naturel", or teme 23e or 28e-f ehow The Madical Expression of the contilled at	Completed	15. Deced (Specify only high				16a. Dece	dent's Usual O kind of work of DO NOT use r	ccupation	most of work	ing	16b. Kind of	Business/Ind	dustry
21	e * 3	πpi	Elementary/Secondary (0-12		Çollege (1-	4or 5+)					-	T-1	-1 0	
2	filed within Hygiene. other then	S	47 5-11-4-11	- ( 1)	4yrs		rood	Servic						rernment
and m	g g g g	Be	17. Father's Name (First, Middle James Darby	9, Last)						ertha	(First, Middle,	Maiden Sum	ime)	
Maryland	s 1 and 2 should by if Heelth and Menta Item 27 is marked other traumatic ev	2		nahin (Tus	o Drietl		105 14-11	- Add (C				. City as Tay	- Ct-4- Tin	0-4-1
Mai	d 2 sho th and traum	i	19a. Informant's Name/Relatio								al Route Numbe			Code)
	1 and 2 Heelth Iem 27 other tra		Edward Be11 / 20a. Method of Disposition	nusbe	and	20b.	Place of Dispo	sition (Name	of		aton, M	20c. Location		wn. State
Baltimore,	0 0 = =		1X Burial 2 ☐ Crematio		emoval from S		cemetery, cre	matory or other	r place)					
를			4 Domaion 5 Other  21. Signature of Funeral Service		m /7	На		Mem Pk.			2, 200			Md.
Ba	permit. Dependr Importe any inju	H	CRO.	PLICOISO	16	h					<b>.</b> 71	WDC 2		
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			shock, or heart failure. L Immediate Cause (Final	st only one	e cause on ea	ach line.		06'	``g. 566		or roophatory an	001,		Interval Between Onset and Death
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	uted	F	cause. Enter Underlying Cause (Disease or injury that initiated events	1										
Ć.	exection and ial-tra	Examiner	resulting in death) Last	C.	Due to (	or as a conse	quence of):							
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89	tificat ig phy as th	ed										- 1		
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ח	ding P h. After t funera	ü	27. Magner of Death  1. ✓ Natural 5 ☐ Pen	dina	28a. Date of (Monti	f Injury h, Day Year)	28b. Time o		Injury at Work?		28d. Describe h	ow injury occ	urred	
sio	Attendii deeth. ctor: A y the fu	cati	2/☐Accident inve	stigation				М	1 Tes	2 No				
Division	or At	Certification;	4 Homicide	rmined	28e. Place buildin	of Injury - At h ig, etc. (Spec	nome, farm, st ify)	reet, factory, of	ffice		28f. Location (S City or Tow	treet and Nut n, State)	n <i>ber</i> or Rura	I Route Number,
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0	(2)		30. Name and address of person	who	pleted cause	e of death (Ite	т 23а) (Туре,	Print	-1 3	( )		_0_	de	7 0 0
K	(2)		U.D.P. O	1 7	N	1091	15C	I I	1	1500	hirst	<b>7</b> 1	Apl	1100-1 P
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10a State

Director

Completed by Funeral

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Physician

/Medical

Examiner

**Funeral** 

Director

r then "natural", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28525 State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 18, 2006 РМ Auq. 8:37 Robert Lee Butler 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) Aug • 23, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Country) Months 1 € M 2 □ F 69 1936 577-46-5027 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 21 No Alexandria Fairfax 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22309 USA 4613 Lawrence Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sanitation Worker Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lelia Mae Dukes Lance Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mechelle Wilkins - daughter 9503 Small Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Harmony Mem. 8/26/06 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bell and Johnson Funeral Home PA 21. Signature of Funeral Service Ligense 6503 Old Branch Ave. Temple Hills, MD 20748 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seph cemia Due to (or asya consequence of): suiddle stown to be preamoning Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed v Department of Heath and Mental Hygier Important: if Item 27 is marked other transportant any Injury or other traumatic event.

Examiner Physician/Medical þ Completed Be ို

physician and s the burial-transit 25 attending to for use as signed t this ieral Director: After th Certification;

25. Was case referred to medical examiner? 27. Manner of Death

The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital or Attending Physician: death. To the Hospitel or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Registrar

29b. Signature and title of partier rahnenm D

1 Yes 2 No

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

6 Could not be 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Impatient

28a. Date of Injury (Month, Day Year)

D11055120

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Santien Avenue SE Suk 310 Washing by DC 20032

32. Registrar's Signature

mi)

31. Date filed (Month, Day, Year) AUG 2 4 2006

5 ☐ Pending

investigation

State

2 ER/Outpatient 3 DOA

28b. Time of

State of Maryland / Department of Health and Mental Hygiene Reg. N. 2006 28526 1 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:34P M AUGUST 2006 BRADLEY HANNAH Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 □ M 2 🖾 F 13 1931 VIŘGÍNIA APRIL Director 577-40-8697 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f ehow th and Mental Hygiene. 77 is marked other than "natural", or Items 23s or 28s-f ehov traumatic event, the Madical Experience must be notified at 1X Yes 2 No WASHINGTON Director DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20018 2809 MYRTLE AVENUE N.E. U.S.A. by Funerai Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo 1 Never Married 2 TMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: BLACK Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 2 yrs REGISTERED NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENNIE CARY SEDLEY RANDOLPH ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health (item 27 i 2809 MYRTLE AVENUE N.E. WASHINGTON, DC 20018 LAVERNE SMITH/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages i Department of I Importent: if ite ony injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 08/25/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sign. Division of Vital Records, Completed by Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy finding: available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes No 1 Tes 2V No certificate Hospital or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ၉ repatient 2 ER/Outpatient 3 DOA No this. After thi te of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation i Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funerel Direct filled in by 4 | Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date sigged (Month, Day, Year) 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 31. Date filed (Month Day, Year) State Registrar AUG 2 3 2006

State of Maryland / Department of Health and Mental Hygien 2006 28527 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 08-20-2006 4:42 A JOSEPH ANDRE BUTLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-06-1953 9. Birthplace (State or Foreign Country)
Wash., D.C. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 M 2 ☐ F Months Hours Director 579-74-5891 52 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f shov other treumatic event. The Medical Examiner must be notified at 1 Tes 2 □ No Washington Director D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 2t enty fullury or other treumatic event, the Madical Example. U.S.A. 20011 5003 7th Place, N.W. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠿNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Plant Operator 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruth Annie Mae Newman Robert Selvia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5003 7th Place, N.W. Wash., D.C. 20011 Andrea Butler/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Na Burial 2 ☐ Cremation 3 ☐ Removal from State 08-26-2006 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foreral Service Licenses Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 - MO1453 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or a a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Marner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) ٥ eted cause of death (Item 23a) (Type, Print) 45516 31. Date filed (Month, Day, Year) State Registrar 2006

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	Funeral Director		5. Social Security Nu 084-12-68 Usuel Residence of I	14	Sex 7. A 1 M 2 XF 8	ge (In yrs. Ia	rst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	s. 8. Date of (Month, JULY	Day, Yea	9. Bird Co MIS	thplace (State or Foreign ountry) SISSIPPI
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Maryland 21215-0036	be fited within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural", or Items 23a or 28e-f ehow ovent, the Medical Examiner must be rigitlied at	by Funeral	11. Marital Status 1 □ Never Marrie 3 🖾 Widowed 4	_	12. Was Deceden Armed Forces 1 Yes 2X If Yes, Give Year or Dates	?]No		Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Put Specify:	(Specify Yes or erto Rican, etc.)	No-	14 Race - Ame Black, Whit Specify: B1	e, etc.
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VITAI	ysician: The is certificate director, pag	BeC	25. Was case referre	ed to medical					26. Place of D	eath Check on		40 10163	22110
5	this at din	2	1 ☐ Yes 2 ☑ N 27. Manner of Death	lo	Hospital: 1 Inpat	tient 2 E	R/Outpatien		4 🗆 Nursing			6 Other (Spe	city)Hospice
	ling Aftar una	tlon	1 ⊠ Natural 2 ☐ Accident	5 Pending	(Month, D	ay Year)	Injury	Wor	yat k? Yes 2 ∐No	28d. Descri	e now in	lary occurred	
DIVISION	al or Attend s efter death il Dirsctor:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of I	njury - At hor atc. (Specify)	me, farm, stre	eet, factory, office		28f. Location City or	n (Street Town, Sta	and Number or Ri	ural Route Number,
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ı	To the To the comp	¥	29b. Signature and t	itle of ceruffier *		, /	N	29c. Licens	e number 6523			Date signed (Mont	
R	(20)		30. Name and addre	ss of person who	completed cause of gs-Shippma	death (Item	<sub>23a)</sub> ( <sub>Туре,</sub> O Basi	Print) .1 Court,	Largo,	MD 2077	4		
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			For State Registrar	State	of Marylan		artment rtificate				ental Hy	giene Reg. N	006	28529
0	Dhusisi		1. Decedent's Name (First, Middle	, Last)							2. Date of De. Month	ath Day	Yea	3. Time of Death
, AS	Physici /Medio	2	Shirley	Ann	Berry						August	23	200	
	Examin	er	4a. Facility Name (If not institution		iumber)				Location of	of Death			County of De	
A Section		Carlotte .	Kline Hospice 5. Social Security Number	House 6. Sex	7. Age (In yrs.	last birthday)	If Under	t. A	li Under	24 Hrs.	8. Date of Bird	h	reder	1 C K Lirthplace (State or Foreign
	Funeral Director		579-42-8661	1 □ M 2 😿 F	7		Months	Days	Hours	Min.	(Month, Da SEPT . 1	y, Yea <i>r)</i>	(	Sountry) Shington, DC
	P.		Usual Residence of Decedent		10.00	-								
	show	25	10a. State 10b. County Maryland Fr	ederick		y, Town or Lo Freder								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number	CUCLICK		rreder	10f. Zip	Code				10a. Citiza	en of What	Country?
	3a or		1513	Andover	Lane				21702			·		States
	death	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ar Bfack, W	nerican Indian,
36	or it	by Fu	1 Never Married 2 Marr	ied 1 ☐ Yes	2 ⊠ No Give		1 ☐ Yes 2		Specify:		,		Specify:	White
Ş	ified within 72 hours after death with the Maryland of Applene. I thygiene. I the Maclical Exacultarinate or and the modified at yent. The Maclical Exacultarinate or modified at		3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:	16a. Dece	dent's Usua	f Occupa	ation			16b. Kin	d of Busines	ss/Industry
212	nin 72	plet	(Specify only highes Efementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	during mos )	t of workir	ng			,
7	giene giene er the	Completed	12	00,1090		Admin	istra	tion						overnment
Maryland 21215-0036	9 7 3	Be	17. Father's Name (First, Middle,								(First, Middle,	Maiden S	iumame)	
<u>Z</u>	should be nd Mental marked o umatic eve	은	Thomas  19a, Informant's Name/Relations	Goode		10h Maili	no Addroon	(Stroot o		ebill	I Route Numbe	Mason		. Zin Coda)
<u>B</u>	nd 2 sl alth an 27 ie r ir traur		James M. Berry				-				letown	-		
ē,	the He		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	Ţ		ate			or Town, State
altimore,	Pages nent of int: if it iry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>		n State	shingto	•		1	8/28/	/2006	Suitl	Land.	Maryland
ă	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service	Licensee					s of Facilit	y Sta	uffer	Funer	al Ho	mes, P.A.
m 	205 2 3		Saymond	Tell	non						ke/ Fr		ck, M	
	Physician		23a. Part I. Enfer the disease, or shock, or heart failure. List fmmediate Cause (Final disease or condition	only one cause or	each line.	Pancre		Can		cardiac o	r respiratory ai	rest,		Approximate Interval Between Onset and Death
40	/Medical Examiner		resulting in death)	Due t	o (or as a conseq	uence of):								
85	ed sit	ulner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due t	u (ur as a cunseq	(vanca ut):								
oʻ	certificate be executed ding physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conseq	uence of):							_	
8760	ate hy:	dlcal		d			<del></del>				·	<u> </u>		
Box 6	eath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pregna	ancy						25	3d. Date of o	delivery
o B	0 0	Physician/Med	in the past 12 months?  1 Yes 2 XNo 9 Unknown		e birth 2 □ Feta gnant at time of d known		Ectopic pre Other (spe					10	Month	Day Year
ت. ت	s that ned by e deta	by Ph	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying ca	use give	en in Part I		23e. Did t	obacco us	e contribute	to the cause of death?
ecords,	law requires that the as been signed by th 2 should be detache										10	∕es 2∏X	No 3□	Probably 4 Unknown
Seco	e law re has ber e 2 shc	Completed									24a Was autop		24b. Were prior to death	autopsy findings available o completion of cause of
	<b>hysician:</b> The law his certificate has l I director, page 2 s	e Col	or Wee and others do and in the	-							1 ☐ Yes	2 No	1 🗆 Y	
	Physician: this certifica ral director, I	0 B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe			(Check only one 5 ☐ Resid		ViOther (S	Hospice
	ding P h. After t funera	tlon: T	27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time o		Bc. Injury Work		2	28d. Describe I			House
Division	spitel or Attending ours after death. neral Director: After filled in by the fune	ertification:	2 Accident investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Pla	ce of fnfury - At h Iding, etc. (Specil	ome, farm, st y)	reet, factory,				28f. Location (3 City or Tox		Number or	Rural Route Number,
	Ho Fur	edical Co	(Check only 2 Medical	g Physician: To t Examiner: On the	basis of examina	owledge, deat	h occurred a	at the tim	ne, date an pinion, dea	nd place, a	and due to the	cause(s) a	ind manner blace, and d	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	one) 29b. Signature and title of certifier		anner stated.		29c.	. License	number			29d. Date	signed (Mo	nth, Day, Year)
1	⊢s⊢ö		1 hand	1-6	is	M(	)	00	50	990				24, 2006
(	6		30. Name a a dress of person	who complete	use of death (Item	п 23а) (Туре,		-					1	/
	)		Jonat	han Gri	fe / 801	Toll	House	Ave	./ Fr	eder	ick, Ma	ryla	nd 21	1701
6	Sta Registr		31. Date filed (Month, Day, Year) AUG 2	g 2006 32.	agistrar's Signa	Ature	mede	•						

State of Maryland / Department of Health and Mental Hygiene 2005 Per INF G859 9-18/06 Jhnorth 28530 Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Wasili Borisow 10:15 A M August 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Romania **Funeral** 1 🕅 M 2 🗆 F 91 577-54-1030 Yrs. Director Sept. 30,1914 Russia Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Boyds Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15432 Conrad Spring Road 20841 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Mayflower Hotel Chef 12 27 le marked othe traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth eny julyry or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Sumame) Be Pascha Detschkova Gabriel Borisow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elfriede H. Borisow/Wife 15432 Conrad Spring Road, Boyds, MD 20841 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory August 23 2006 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Euneral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East RACU. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lung cancer years /Medical resulting in death) Due to (or sea consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificete hes been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2. No 1 Yes 2 No Hospitel or Attending Physicien: After this certific funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending efter death.

Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel c within 24 hours of To the Funeral D completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) licie J. Mistme D59738 August 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 20850 Alicia T. Mistry 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 24 AUG Registrar

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Borisou

			1 - For State Registrar	State of	f Marylan	•	artment o <i>tificate</i>			ental Hyو ا	giene Reg. No. 2 (	006	28531
			Decedent's Name (First, Middle, Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medic		Edward Lee Becraf	t						August			12:35am M
	Examin		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, To	vn, or Locati	ion of Death		4c. Cour	nty of Death	
			Shady Grove Adven				Rockv					tgomer	
	Funeral Director		5. Social Security Number 6. Sec. 18	M 2□F	7. Age (In yrs. 64	last birthday) Yrs.	Months D	ays Hou	der 24 Hrs. Irs Min.	8. Date of Birt (Month, Da Oct. 16	y, Year)	Cour	place (State or Foreign htry) Land
	p ,	1	Usual Residence of Decedent		10c Cit	v. Town or Lo	antina						0d. Inside City Limits
	arylar	٦	10a. State 10b. County		Toc. Cit	y, lown or Lo	cation		-				1  Yes 2 No
	Ba-f	ecto	Maryland Montgome  10e. Street and Number	ry	Roc	<u>kville</u>	10f. Zip Co	do			10g. Citizen o	of Milest Cour	
	death with the Maryland ms 23a or 28a-f show count be notified at	늅					208						,
	ns 23	era	1905 Lewis Avenue	12. Was Dece	edent Ever in U	.S. 13. V			Origin? (Spe	cify Yes or No Rican, etc.)	United 14. R	ace - Americ	
20	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show many injury or other traumatic event, the Mudical Examinar must be notified at once.	y Fun	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 21XINo re		fYes, specify 1□Yes 2页			Rican, etc.)	Spec	lack, White,	
3-003e	hour	ed b	15. Decedent's Edu		ates.	16a, Dece	dent's Usual C	ccupation			16b. Kind of		ite
Ċ	in 72 n na	plet	(Specify only highest grad	e completed)	4== 5 . \	(Give	kind of work o	lone during r etired)	most of worki	n <i>g</i>			,
77	r thau	E O	Elementary/Secondary (0·12)	College (1	-40r 5+)	Mecha	nic's	Assist	ant		Montgo	omery	County Gov'
and	othe	Se C	17. Father's Name (First, Middle, Last)					18. M	other's Name	(First, Middle,	Maiden Sum	ame)	
<u>a</u>	uld by	TOE	Howard Elmer Becr	aft				Ler	na Mari	e Lewi	s		
магу	and the	. 4	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (S	treet and Nu	m <i>ber</i> or Rura	l Route Numbe	er, City or Tow	vn, State, Zip	Code)
e, z	and sealth in 27		Janice G. Becraft	(Wife					7	ville,			
o G	Total		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	lemoval from	State 20b. F	Place of Dispo cemetery, crem	sition (Name natory or othe	of r place)		ate	20c. Locatio	n - City or To	own, State
Ē	tant:	. 3	4 ☐ Donation 5 ☐ Other (Specify)			l Souls	s Cemet	ery	8/24/	06	German	town,	Maryland
Баптог	Depar Depar Impor any in		21. Signature of Funeral Service Licens			10 Ga	Name and A East aithers	Deer burg,	Park D MD 20	ol Fune rive 877	rai no	me	
			23a Part1. Enter the disease, or complishock, or heart failure. List only o	cations that c	aused the deat								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		cordia	1 in	farc	hion					Onset and Death
	/Medical		resulting in death)		or as a conseq					-			
	Examiner		Sequentially list conditions		osclero		Carde	vasc	ular	disea	Re		years
	p ii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):							
	and and I-tran	Examine	that initiated events resulting in death) Last	Due to /	or as a conseq	neuce ot).							
8/60,	be ey	al E		Odo to (	(01 43 4 0011004	201100 01).							
ò	icate be executed physician and s the burial-transit	dical		d					<del></del>				
×	death certificate be executed e ettending physician and id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, out	come of pregna	ancy					23d. i	Date of delive	erv
X Q Q	death d for	clai	in the past 12 months?	4□Pregn	irth 2□Feta ant at time of c		Ectopic preg Other (spec					Month	Day Year
o.	the che	hys	9 Unknown	9□ Unkno	nwo					-			
J.	gned be de	á	Part II. Other significant conditions co	ntributing to de	eath but not res	ulting in the u	nderlying cau	e given in P	art I.	23e. Did to	£		he cause of death?
ecord	w requir been si should	ete								24a. Was	20 24	h Wara auto	opsy findings available
r	The ate h page	Completed								autop		prior to co death? 1  Yes	mpletion of cause of
VItal	sicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				- 10		lace of Death	Check only o	ne		
<u>o</u>	Physic this co	ို	1 ☐ Yes 2 No	-		ER/Outpatier				ne 5 Resid		<del></del>	5/)
000	nding P th. :: After t e funera	atlon:	27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date (Moni	of Injury th, Day Year)	28b. Time of Injury	f 28c	Injury at Work?		28d. Describe I	now injury occ	curred	
DIVISION	l or Attenc after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildi	of Injury - At hing, etc. (Special	ome, farm, str fy)	reet, factory, o	ffice	:	28f. Location (: City or To		mber or Rur	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director.	Medical C	29a. Certifier   Check only   2   Medical Exem	nar: On the b	asis of examina	owledge, death ation and/or in	h occurred at vestigation, in	he time, dat my opinion,	e and place, and death occurre	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and man	ner stated.		29c. L	icense numt	ber		29d. Date sig	ned (Month	Day, Year)
			Deice J	Mis	ty M	D		5973		1	_		-
,	(0)		30. Name an address of person who c								Augus	7	
			Alicie T. Mistr	1 990	Med	ical C	inter	Driv	e Ri	sekvill	e, M	20	850
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 4 2	006 32	egistrar's Signa	H 4	all!						

			State of Maryland / Department of Hea  1- State Registrer Certificate of De		al Hygiei	2006	28532
			Decedent's Name (First, Middle, Last)		ate of Death	Day Year	3. Time of Death
	Physici: /Medic		Frances Marie Bricker		gus t	25 2006	1:58 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc			4c. County of Death	
1				rstown Under 24 Hrs. 8 D	ate of Birth		ington
4	Funeral Director			lours Min. (A	Nonth, Day, Ye y 23, 19	ar) Cou	place (State or Foreign intry) any land
	0		Usual Residence of Decedent	, , ,	,		
	arylar show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits  1XXYes 2 ☐ No
	28a-f	ecto	Maryland Washington Hagerstown  10e. Street and Number 10f. Zip Code		100	Citizen of What Cou	
	With With	١٥		1740		USA	, .
	death	nera	17. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hisparial frame of Forces?		Yes or No-	14. Race - Amer Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heetih and Mental Hygiene. Department of Heetin 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Mudical Examinar must be notified at ance.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No Section 1 Yes	ipecify:	1, 610./		nite
Maryland 21215-0036	tura!	ed b	15. Decedent's Education 16a, Decedent's Usual Occupation	n	16b	. Kind of Business/I	ndustry
215	nin 72 in "n	Completed	(Specify only highest grade completed) (Give kind of work done durin life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	ng most of working			,
212	e filed within al Hygiene. I other than " vent, the Wai	Com	11 Owner/Operato	<u> </u>		Restau	ant
ם	d oth	Be		. Mother's Name (Firs			
	should be nd Mental marked o umatic eve	은	John Frederick Griffith  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and I	Lula Alic		•	in Code)
Z	ath and 2 st		Abram L. Bricker, Jr Son 845 Chestnut St			•	21740
a .	f Heel		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		. Location - City or 1	
ê .	Page nent o nt: If ry or		1XXX Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) Green lawn Mem. Park	Aug. 29. 2	2006 W	illiamspor	rt.Marvland
Baltimore,	permit. Pages 1 Department of It Important: If ite eny injury or ot		21. Signature of Furreral Service Usins 022 Name and Address of				
_	# # # # #		425 S. Conocc			liamsport	
П			23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	UC AIRU	AY D	1 Sease	54 cas.
1	Examiner		Premoner				24 hous
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				,
	death certificate be executed e attending physicien and id for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c				
8760,	be ex sicien burial	ical E	Due to (or as a consequence or).				
687	ificate g phys		d				
Вох	eath certific attending p	Physician/Med	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	,
O. H	e dea the att	sici	in the past 12 months?  1			Month	Day Year
P.0	that the de led by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	9 <u>5</u> 9	d by			1 XYes	2 □ No 3 □ Pro	bably 4 Unknown
00	w requir	Completed			24a. Wasan	24b. Were au	opsy findings available
Œ	0 5 0	mo di			autopsy performed I ☐ Yes 2 🛣	? death?	ompletion of cause of
	sician: Th certificete irector, pag	BeC	25. Was case referred to medical examiner?	5. Place of Death  Ch			
o t		၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home			ufy)
no.	ding F	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Decytlent investigation  Manuel 1 Pending (Month, Day Year)  2 Natural 1 Pending (Month, Day Year)  Manuel 28b. Time of Injury Work?  1 Yes	280. I	Describe how i	njury occurred	
Division	Attending Physician: r death. sctor: After this certificator, by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. L	ocation (Stree	t and Number or Ru	ral Route Number,
Ö	tel or rs afte el Dir	Cert	4 Homicide building, etc. (Specify)				
	To the Hospitel or Attending Phys within 24 hours attendent. To the Funerel Director: After this completely filled in by the funeral di	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, of the basis of examination and/or investigation, in my opinion and manner stated.				
	To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License nu	umber	29d.	Date signed (Monti	, Day, Year)
	F \$ F 0		Monzen of Straig D28	2365		8-28-	-06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				-
10/	1-2		manzav 2. SHAPA 368 nelles Stree	el- Horger	steru	MO 2	1742
	Sta Registi		31. Date filed (Monifi, Day, Year)  AUG 2 8 2006	0			
DHA	AH 17 Rev 1/2		Mou ~ 0 2000   Filmer B. Sparker				
			ORIGINAL				

		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of I	lealth and M Death		gien <b>e UU</b> b 1eg. No.	28533
			1. Decedent's Name (First, Middle, L	ast)	-			2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medio		PAULINE SCOT	r bedwell		·····		AUGUST	29, 2006	12:20 P <sup>M</sup>
1	Examir		4a. Facility Name (If not institution, g CHESTER RIVER M			4b. City, Town, or CHESTE	Location of Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. 216–18–8361	Sex 7. Ag 1 ☐ M 2 【XF	e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 07/12/	1924 9. B	irthplace (State or Foreign Country) MD
	pue *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	ō	MD KENT		CHESTERTO					1 □ Yes 2X No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th with	aiD	23048 OLD FAIRL	EE ROAD		21620			USA	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No	Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2ሺ No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: WH	
5-0	72 hc	etec	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup	during most of work	ing	16b. Kind of Busines	ss/Industry
121	within sne. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired RETARY	1)		FURNITUR	E
d 2	filed with Hygiene. other than		17. Father's Name (First, Middle, La	st)	5301		18. Mother's Name	e (First, Middle,	Maiden Sumame)	
Jan	Mental Mental rked c	To Be	LEE SCOTT				PEARL F	OUNTAIN		
Maryland	and 2 should be filed withir salth and Mental Hygiene. n 27 is marked other than ier treumatic event, the Mi		19a. Informant's Name/Relationship THOMAS BEDWELL/S			MAIN ST.			r, City or Town, State 21610	, Zip Code)
Baltimore,	Page nent c		20a. Method of Disposition 1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of Disposementery, cre CHESTER (	matory or other place	(a)	1/2006	20c. Location - City CHESTERTO	
Balt	permit. Departr Imports eny inji		21. Signature of Funeral Service Lic	elfeli		2. Name and Addre FELLOWS 1 130 SPEER	ss of Facility HELFENBEI ROAD, CH	N & NEW	NAM FUNERA WN, MD 216	L HOME, PA 20
7	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or construction of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	ne.	/	7	_	Deserve	Approximate Interval Between Onset and Death O JULIA
8760,	cate be executed physicien and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
9	ificate g phy: as the	edic		u						
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,	<del></del>	23d. Date of d Month	lelivery Day Year
	signed by	d by Pt	Part II. Other significant conditions	-	out not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	: 1	to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	sician: The law req s certificate has beer lirector, page 2 shou	Completed by	Uning	lin degend	est dies	As mel	litus	24a. Was a autop perfor	sy prior t rined? death	autopsy findings available o completion of cause of ?
ita	an: Tifical	0	25. Was case referred to medical				26. Place of Deat		-70-1	95 2 140
<b>\</b>	ysici	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	lence 6 □Other (S)	pecify)
sion o	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation:	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigal	1	ury 28b. Time of Injury	Wor			now injury occurred	
Divi	tel or Att rs after d ai Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	286. Place of in	jury - At home, farm, st tc. (Specify)	reet, lactory, office		28l. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	n 24 hou. he Funer	Medical Certification:	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	of my knowledge, dea of examination and/or in tated.	th occurred at the tirnvestigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Σ	29b. Signature and title ol certifier	aminer: On the basis of and manner standard ma	>	29c. Licens	e number 7036 - M	ld.	29d. Date signed (Mo	nth, Day, Year)
	5		30. Name and address of person who Sason IC, No 5 3	in completed cause of in $\mathcal{D}$ 5/	death (Item 23a) (Type Woshing	Print) for Are.	Cleast	atom M.	11 2162	3
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3	32. Regist	r's Signature	Last,				
DF	MH 17 Rev 1/2	2001				-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier® (1) 0 C

			1 - For State Registrar	State of Maryla	Cen	tificate of L	eaith and M Death		eg. No.	28534
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Melva Lee	Bruden				2. Date of Dear Month AUGUS	th Day Year A Day Year	3. Time of Death
	Examir		4a. Facility Name (If notrinstitution, give st	reet and number)	Center	4b. City, Town, or	CY+OUY		4c. County of Deat	h
	Funeral Director		214-26-0199	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 17,	9. Bird 1927 MAR	hplace (State or Foreign untry) YLAND
death with the Maryland	show	2	Usual Residence of Decedent  10a. State 10b. County  MD KENT	10c. (	ROCK H					10d. Inside City Limits 1 X Yes 2 □ No
M ett	r 28a-f matifie	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of What Co	
ath with	23e o	ralD	4874 CROSBY ROAD				661		USA	
3-UUSO 72 hours after de	i Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23e or 28a-f show other traumatic event, the Medical Executiver is untitle at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	i	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	ene. than "natur na Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give k	ent's Usual Occupa ind of work done o O NOT use retired, MSTRESS	ation furing most of worki )	ng	16b. Kind of Business	findustry
Da filed	other vent, t	Be Co	17. Father's Name (First, Middle, Last)		DII,	IIDIREBB	18. Mother's Name	(First, Middle,	1977	
ylar outd b	Menta varked	To	THOMAS WELDON JO					LEE THO		
Mar and 2 sh	ealth and m 27 is m her traum		19a. Informant's Name/Relationship (Type BETTY JOINER/SISTE				ROCK HAL		r, City or Town, State, 2 1661	Zip Code)
Saitimore,	Department of He Important: If Item any injury or other once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Place of Dispos cemetery, crem SLEY CHA	ition (Name of atory or other place APEL	8-27-		20c. Location - City or ROCK HALL,	
	Depart Import any inj once.		21. Signature of Funeral Service License	1/1/2					I FUNERAL H	
P	hysician		23a. Part1. Enter the disease, or implification shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	ath. Do not ente	r the mode of dying	g, such as cardiac c	or respiratory arr	est, MD 21620	Approximate Interval Between Onset and Death
1	Medical xaminer		resulting in death)	Due to (or as a cons	equence of):	7				
uted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
os/ou,	physician and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conse	equence of):					
Gentle Car	e attending d for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ecords, P.O.	n signed by	by	Part II. Other significant conditions condit			derlying cause give	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
ř	ate has	Completed						24a. Was a autops perform	24b. Were at prior to death?	utopsy findings available completion of cause of
OT VITAL	is certific director,	o Be	25. Was case referred to medical examiner?	ospital: 1 hpatient 2	☐ ER/Outpatient	3□ DOA Othe	26. Place of Death		ne) ence 6 □Other (Spe	
<b>C</b> 2	9 6	F	1 Yes 2 No  27. Mapner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)		28c. Injury Work	4   Nulsing no		ow injury occurred	(City)
= 7	9 = -	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (S. City or Town	treet and Number or Rin, State)	ural Route Number,
Hosnit	24 hours al e Funeral D etely filled i	edical (	29a. Certifier Check only one) Certifying Phys	ician: To the best of my ker: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and manner as date and place, and due	s stated. e to the cause(s)
Tothe	within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License			29d. Date signed (Mont	
17			Jun Ky	cos mis		Md-	01703	6	812410	(
1 -	ns		30. Name and address of person who con	mpleted cause of death (It	em 23a) (Type, F Woshi'n	entra Az	e. Ches	testown	8/24/0 Md 2/6:	20
6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	202	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		how the		·		

Please Type or Brissin, Black Indeline Into Ensure At Copies Are Legible.

			1 - For State Registrar	State of M	laryland / Der	partment of	Health ar	nd Mental H	ygiene Reg. No.2	006	28535
	12-12		Decedent's Name (First, Middle, La	ist)				2. Date of E	Death Day	Year	3. Time of Death
	Physici /Medio		Ronald Cicala					August	31	2006	8:18 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, gi				n, or Location of	Death		ounty of Death	1 - 1
	S*	3	Anne Arundel Medi 5. Social Security Number 6.		ge (In yrs. last birthda	Annapo.		4 Hrs. 8. Date of E		e Aruno	leL place (State or Foreign
	Funeral Director		220-76-3370	1X□M 2□F	99 (111 yrs. 14st billilida 59 Yrs.	Months Da		Min. 10/01/	1946	Coui	ington D.C.
migs.			Usual Residence of Decedent		37			10/01/			
	rylan		10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f	Director	Maryland Anne Aru	ndel	Annapoli				T		
	with th	Die.	10e. Street and Number		_	10f. Zip Cod	θ			n of What Coul	
	eath ve 23	Funerai	3016 Arundel on t	he Bay Rd			of Hispanic Origi	n? (Specify Yes or !	-	d State	
10	r Iten	Fun	1X Never Married 2 Married	Armed Forces	?	II Yes, specify C	uban, Mexican,	Puerto Rican, etc.)		Black, White,	
93	ref, o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:		S	pecify: Whit	te
5	within 72 hours after death with the Maryland ane. then "neturel", or Iteme 23e or 28e-f ehow ne Madicel Expriner mast be notified at	Completed	15. Decedent's E (Specify only highest g		(Ĝi	cedent's Usual Oc ve kind of work do	ne during most o	of working	16b. Kind	l ol Business/în	dustry
12	within then.	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	. DO NOT use re abled	tirea)				
20	Hygi ther ther		17. Father's Name (First, Middle, Las	t)	DIS	antea	18. Mother	s Name (First, Midd	lle, Maiden Si	umame)	
an	should be nd Mental marked c matic eve	To Be	Cafiero Cicala				June	L. Higgi	ns		
ary	o, c a	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Str		or Rural Route Num		Town, State, Zip	Code)
Σ	ss 1 and 2 of Health a Item 27 is		Philip Calabro /	'Guardian	3317	Powder 1	Mill Roa	d, Hyatts			
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State		rematory or other	place)	Date		ition - City or To	
Ē	Pages ment of I		4 Donation 5 Other (Spec		Cedar H	ill Ceme		9/06/06		and, Ma	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If eny Injury or 2009.		21. Signature of Funeral Service Lice	ensee				George P. sland Rd.,			
	<b>*</b>		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause y one cause on each	d the death. Do not e	enter the mode of	dying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
Ya.	Physician		Immediate Cause (Final disease or condition	TE	ERMINAL	ARMYT	HMIA				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or a	Enninge s a consequence of): Elzuno I					4	
AN	LAGITITIE	_	Sequentially list conditions.	b	EIZUPE D	DISORDGI	2			AND A	
7	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence or.	d non to	-	Carlotte Mark	A EDIC	A STATE OF THE STA	
v_	s be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	C.	s a consequence of):		rent.	THE WON THE	V		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicail		d			00	all			
9	ntifica ng ph s as th	Med	IF FEMALE:					7	1		
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregna			23	d. Date of deliv Month	ery Day Year
о. П	at the dea by the a tached fo	/sic	1 Yes 2 No	4∐Pregnant : 9∐ Unknown	at time of death	5 ☐ Other (specify	′)		-		,
<u>α</u>	that the		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Di	d tobacco use	contribute to t	he cause of death?
ds,	es De pe	d by	Mental Retardat	ion				1[	]Yes 2□	No 3∏Prol	bably 4 unknown
00	w requir	Completed						24a. W		24b. Were auto	opsy lindings available
Re	The lav	dmo						au pe	topsy rformed?	prior to co death? 1  Yes	mptetion of cause of
Vital Records,		0	25. Was case referred to medical				26. Place	of Death (Check on)	V -	12.103	2010
<b>₹</b>	ysic lis ce direc	To B	examiner? 1 XYes 2 □ No	Hospitat: 1 ☐ Inpar	tient 2 ER/Outpat	ient 3 DOA	Other: 4 Nur	sing Home 5 Re	sidence 6	Other (Speci	fy)
n of	ding Ph h. Atter th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, D	jury 28b. Time ay Year) Injur		njury at Work?	28d. Describ	e how injury	occurred	
sio	at at	cati	2 Accident investigati 3 Suicide 6 Could not	he			1 ☐ Yes 2 ☐ N		(0)		
Division	or At uffer of Direct in by	Certification:	4 Homicide determine	a Zoe. Place of the	njury - At home, farm, etc. (Specify)	street, factory, off	ice		Town, State)	Number of Hur	al Route Number,
П	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune		29a. Certifier 1 Certifying	hysician: To the hes	st of my knowledge, de	ath occurred at th	ne time, date and	place, and due to the	ne cause(s) a	nd manner as	stated
	24 hos Prun etely	edical	(Check only 2 Medical Ex	miner: On the basis	of examination and/or	investigation, in r	ny opinion, death	n occurred at the tim	e, date and p	lace, and due t	o the cause(s)
	To th within To th	Me	29b. Signature and fulle of certifier	445		29c. Lic	ense number		29d. Date	signe (Month,	Day, Year)
			) Cepul			1	D3199	7	9/	3/06	
	H		30. Name any ddress of person wh	completed cause of	death (Item 23a) (Tyr	pe, Print)	(b:-	- A-11	an in	a. 0 3	1401
	1		HND NOW GOLD	or MI) 2	003 Media	est Phwy	1 0 = 10	O TNNA	TELLI,	(VV) 2	-1/01
	St. Regist	ate :	29b. Signature and fulle of certifier  30. Name any address of person wh  AND NAW GOAD  31. Date filed (Month, Day, Year)	00 32. gis	strar's Signature	Law.					
100	9.01		0 1 1 1 0 /	UUD LEDOR	13.2 1 1h L						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 U 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 22, 5:00 A 2006 Frank J. Crawford, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ft. Washington

FUnder 1 Year | FUnder 24 Hrs. | 8. Date of Birth

Annths | Days | Hours | Min. | April 1, 1928 Prince George's Ft. Washington Health & Rehab, Center 9. Birthplace (State or Foreign North Carolina 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1**X** M 2 ☐ F 78 Director 239-36-1243 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Wadical Examinar must be notified at 1 ☐ Yes 2 X No Ft. Washington Prince George Maryland Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 20744 8201 Reppy Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 1 XiYes 2 □ No WIII If Yes, Give 11. Marital Status 1 Never Married 2 Married Specify: White 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 11th Illustrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events. Erma Touchstone Frank J. Crawford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8201 Reppy La. Ft. Washington, Md. 20744 Joyce L. Crawford/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1)XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatiop 5 ☐ Other (Specify) / 8/25/06 Cheltennam, MD. Md. Veterans Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home PA of Funeral Service Licens Rs 6160 Oxon Hill Road Oxon Hill, Maryland 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardinvarelar Therpsulonotic **Physician** ead /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physicien detached for use as the buria Physician/Medicai IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown After this certificete has been signed by tuneral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes XX No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: XX Nursing Home 5 - Residence 6 - Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 X Natural 5 Pending after death.

Director: Aft
d in by the fun 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide thin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier چ 08-22-2006 025365 1 (Tel 11 ring Ster Rd & 101, foit washington mp 20785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) min. SIDAROUS Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 3 2006 Registrar

	1	For State Registrar	State of Maryland		irtment of h tificate of			Reg	ene 20	06	2853
Physicia /Medic Examin	in al	Decedent's Name (First, Middle, Last)     VERNA L. CASSI     Facility Name (If not institution, give st			4b. City, Town, o	or Location o	Z	Date of Death Month	Day 26 20 4c. County of		3. Time of Death
Funeral Director		FREDERICK MEMOF 5. Social Security Number 6. Sex 476-22-7104	HOSPITA 7. Age (In yrs. las 7. 7. Age (In yrs. las	st birthday)	FREDE If Under 1 Year Months Days		24 Hrs. 8	Date of Birth		DERI 9. Birthpla Countr	ce (State or Foreign
a-f show lifted at		Usual Residence of Decedent 10a. State 10b. County MD Freder		Town or Lo	derick						I. Inside City Limit 1 ☐ Yes 2 🗶N
iene. rthan "natural", or Items 23a or 28a-f ehow tha Medical Examinar must be notified at	Funeral Director	10e. Street and Number 8200 Blue Heron  11. Marital Status 1 Never Married 2 Married	Dr. 1-B  2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ②No	. 13.	10f. Zip Code 21 Was Decedent of f Yes, specify Cub	.701 Hispanic Orionan, Mexican	gin? (Speci		14. Race	JSA - America c, White, et	n Indian, c.
n "natural", or Wedical Exami	Completed by F	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12)	If Yes, Give Year or Dates:	16a. Dece (Give life.	1 ☐ Yes 2 ⚠ No  dent's Usual Occu kind of work done DO NOT use retire	pation	t of working	7	Specify:	siness/Indu	ite stry
nd Mental Hygiene marked other tha umatic event, the	To Be Com	12 17. Father's Name (First, Middle, Last) Victor Heino	onego() to on,	Hom	emaker	1		First, Middle, M Matalar			
Health ar tem 27 le other trau		19a. Informant's Name/Relationship (Type Thomas G. Cassidy 20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ XBC	, Sr. husband	820 ice of Dispo	ng Address (Stree O Blue F estion (Name of matory or other pla	leron !	Dr. 1	-B, Fred	derick, Oc. Location	MD 2 City or Tow	21701 m, State
Department of important: If it eny injury or o		Donation 5 Other (Specify)  Signature of Funeral Service License  Occupit  M. Mary	St.	Andr Gr	ew Cemet 2. Name and Addr ove—Bowe	ery ess of Facility	08/30 y 50 Funer	/2006   S. Eroa al Home	Waynest I St. W , Inc.	oro, aynes	PA Shoro, PA 1726
ny sicien and Medical Medical Medical xaminer sas the prival-transit	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or rijury	Due to (or as a conseque	Yon	ner the mode of dy	A A	ten	//	Deag		Approximate interval Between Onset and Death
	Cause (classes of injury training in death) Last   Cause (classes of injury training in death)   Cause (classes of injury training injury train								23d. Dat Mod	e of deliver	y Day Year
been signed by should be detac	ρ	Part II. Other significant conditions con	tributing to death but not resul	lting in the u	inderlying cause g	iven in Part	l.	23e. Did tob	_		cause of death? bly 4 □Unkno
this certificete has been signed by the ral director, page 2 should be detache	Completed					00 81	- of Dooth	24a. Was ar autopsy perform 1 Yes 2	ned? No	Were autoportor to condeath?	sy findings availated by the second systems of the second systems
	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No F  27. Manner of Death 1 Ratural 5 Pending investigation		ER/Outpatie 28b. Time ( Injury	of 28c. Inj	ther: 4 🗆 N	ursing Hom	ne 5 Reside 8d. Describe ho	nce 6 🗆 Oth		)
rel Director led in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	)				8f. Location (Sti City or Town	, State)		
within 24 hours after death.  To the Funeral Director: After it completely filled in by the funeral	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier	sician: To the best of my knowner: On the basis of examination and manner stated.	ion and/or i	29c. Lice	time, date a ropinion, de	nd place, a ath occurre	d at the time, da	ate and place, 9d. Date signe	and due to d (Month, I	the cause(s)  Day, Year)
H-∜ Sta Regist	ate	30. Name an address of person of occurs of the control of the cont	212, MO. 32. Pagistrar's Signat	801	Toll	How	re A	ne F	redes	iel	06 MO2

			State of Maryland / Department of State of Maryland / Department of Certificate of Maryland		Hygiene 2005	28538
		4	1 Decedent's Name (First, Middle, Last)	2. Date of	f Death	3. Time of Death
L	Physici /Medic		WAYNE ALVIN CAIN SR.	Month &	Day Year	6:30 AM
8	Examin	er	Clastertown Nuising Rolab Claste	, or Location of Death	4c. County of Deat	
	Funeral Director	¢	5. Social Security Number  6. Sex  M 2 F  7. Age (In yrs. last birthday)  Months Day  Months Day		1 Day, Yearl 8 9. Bird	thplace (State or Foreign puntry)
	Aaryland I ehow	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	nd		10d. Inside City Limits 1 Yes 2 No
	hours after death with the Maryland turel', or Iteme 23a or 28a-1 ehow al Exeminer must be notified at	Director	10e. Street and Number 10f. Zip Code	10.	10g. Citizen of What Co	ountry?
	ter death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	f Hispanic Origin? (Specify Yes or Juban, Mexican, Puerto Rican, etc.	or No- 14. Race - Ame Black, Whit	
-0036	hours aft turel', or	by	3 ☐ Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occ		Specify: B	ack Andustry
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. id other then "naturel; or fleme 23a or 28a-1 show event, the Madical Examiner must be notified at	Completed	(Specify only highest grade completed)  Elementary/Secondary(9/2)  College (1-4or 5+)  (Give kind of work don life. DO NOT use reti	ne during most of working	Chestert	own
	should be filed and Mental Hygi marked other umatic event, it	o Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ddle, Maiden Sumame)	
Maryland	C1 (0 = 66	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailin, Address (Stre	et and Number or Rural Route Nu	umber, City or Town, State, 2	Zip Code)
nore,	0 0		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Date 8/2(4/0/0	2 c. Location - City or	Town, State
Baltimore	permit. Pag Department Important: I any Injury o		21. Si na ure of Fin (at S. vice Lice; see	in s of Facility	by tray MA	211.18
(8%)	4		23a. Rary. Enter the disease, or complications that caused the death. Do not enter the mode of disease, or heart failure. List only one cause on each line.	ying, such as cardiac or espirato	ory arrest,	Approximate Interval Between
が一般	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Authorizing Smbol Sm	ism		Onset and Death Minutes
Δ.	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Extra Underlying.			
oʻ.	icate be executed physician and s the burial-transit	Examine	causé. Enter Underkying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
38760,	icate be physicia s the bur	dicai	d			
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \  Yes \  2 \  No \  9 \  Unknown \  23c. If yes, outcome of pregnancy 1 \  Live birth 2 \  Fetal death 3 \  Ectopic pregnancy 5 \  Other (specify) 9 \  Unknown \  9 \  Unknown \  1 \  Dregnant at time of death 5 \  Other (specify) \  1 \  Other (specify) \  1 \  1 \  1 \  1 \  1 \  1 \  1 \		23d. Date of de Month	livery Day Year
ds, P.O.	uires that the signed by do be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause		Did tobacco use contribute to	the cause of death?
Vital Records,	ie law require has been si ge 2 should b	Completed	Syndrome & Mobile Eventy	24a. \	Was an autopsy performed? 24b. Were at prior to death?	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical	1 ☐ Y	es 2 No 1 Yes	3 2 □ No
of Vi	hysicia this cer al direct	To B	examiner?	Othor	Residence 6 Other (Spe	ecify)
o uo	ding Ph h. After th funeral		27. Mann   Death   28a. Date of Injury   28b. Time of   28c. Injury   28b. Time of   1   28c. Injury   28b. Time of   28c. Injury   28c. Injur	ury at 28d. Descr Vork? ☐ Yes 2 ☐ No	ribe how injury occurred	
Division	I or Attendi after death Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ce 28f. Locati	ion (Street and Number or Ri r Town, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	time, date and place, and due to y opinion, death occurred at the ti	the cause(s) and manner as me, date and place, and du	s stated. e to the cause(s)
	within To the	Me	200. Olgitataro arra into el controlo	ense number	29d. Date signed (Mont	th, Day, Year)
)	3			21313	8/24/06	
_	3) ms		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KIN K. WIN, 415 Lyashington At  31. Date filed (Month, Day, Year)  AUG 2 5 20 0	re., Chesterton	m, MD 21	620
18	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 5 20 0   32. Registrif's Signature			

			1 - For State Registrar	State of Ma	aryland / Depa		lealth and M Death	ental Hyg	iene2 () () :	6 28539
	Physici		1. Decedent's Name (First, Middle, Last LAURA GREEN COOLE	•			I	2. Date of Deat Month AUGUST	26 <sup>y</sup> 200	3. Time of Death 17:15 PM
	/Medio Examin	_	4a. Facility Name (If not institution, give HERON POINT	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	eath
	Funeral Director		5. Social Security Number 6. Se 531–22–1046	77	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/26/1	921 9. E	sirthplace (State or Foreign Country) IL
	Maryland a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD KENT		10c. City, Town or Lo	cation TERTOWN				10d. Inside City Limits 1X Yes 2 □ No
	or 28	Direc	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What	Country?
036	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other than "naturel", or iteme 23e or 28e-f ehow or other traumatic event, the Medical Example Institute to notified a	by Funeral Director	217 HERON POINT  11. Marital Status  1 🗷 Never Married 2 🗆 Married  3 🗆 Widowed 4 🗀 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:	No I	21620 Was Decedent of Formula of Yes, specify Cuba	Hispanic Origin? (Spe an, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	USA  14. Race - Ar Black, WI  Specify: WI	
21215-0036	within 72 ho ane. then "natur on Medical	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	1+)	tent's Usual Occup kind of work done OO NOT use retired ILIAN EMI	pation during most of workind) PLOYEE	ng	16b. Kind of Busines	
land 2	Hygi other	To Be Co	17. Father's Name (First, Middle, Last) ARTHUR COOLEY		OIV		18. Mother's Name MINNIE (			
, Maryland	and 2 should beth and to 27 is mains or traumal		19a. Informant's Name/Relationship (7) ARTHUR M. COOLEY/				and Number or Rural RE DR., SA			
Baltimore,	permit. Pages 1 end 2 should be Department of Heelth and Menta Important: If Item 27 is marked eny injury or other traumatic ev QDG8.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		20b. Place of Dispo cemetery, crer CHESAPEAR	natory or other place	ce)		20c. Location - City	
Balt	permit. Pa Departmer Important eny injury once.		21. Signature of Funeral Service Licens	12	FI 1.3	Name and Addre ELLOWS H BO SPEER	ess of Facility ELFENBEIN ROAD, CHES	& NEWNA	AM FUNERAI N, MD 2162	HOME, PA
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death)	a	the death. Do not ent		ng, such as cardiac o			Approximate Interval Between Onset and Death Z
760,	te be executed ysicien and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at	2 Fetet death 3	Ectopic pregnance	у		23d. Date of o	detivery Day Year
rds, P.O.	quires that in signed by		Part II. Other significant conditions co	-	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tol		to the cause of death?  Probably 4 Unknown
Reco	ysician: The law requir is certificate has been si director, page 2 should	Completed by	DEMENTIA					24a. Was a autops perform	v prior t	
/ital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	(1			26. Place of Death	(Check only on	е)	
Division of Vital Records,	S S P	ition: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie  28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Injur	over: 4 Nursing Honory at rk?		ence 6 Other (Spow injury occurred	pecify)
Divis	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: Atter thi completely fiiled in by the funeral	Certification:	3 Suicide 6 Could not be determined	286. Place of int	ury - At home, farm, str c. (Specify)	eet, factory, office	2	28f. Location (SI City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours efte To the Funerel Directional Completely filled in I	Medical	(Check only 2 Medical Exam one)	vsician: To the best iner: On the basis o and manner st	of my knowledge, deati f examination and/or in ated.	vestigation, in my	opinion, death occurre	ed at the time, d	ate and place, and d	lue to the cause(s)
	Y Y Y	Z	29b. Signature and title of certifier  A  A	one		29c. Licens	04158		9d. Date signed (Mo $8/2$	onth, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 9 2005

Helen A. Noble, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



21620

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 28540 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 **Physician** 11:45 AM 23 AUG. FERNANDE HOGANS CROUCH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTER RIVER MANOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 1 F 94 Yrs. CANADA Director 096-16-4011 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-1 ehow with jury or other traumatic event, the Medical Examinar must be notified at 2056. 1 Yes 2 □ No Director ROCK HALL MD) KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21661 USA 5707 S. HAWTHORNE AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No WHITE Maryland 21215-0036 Specify Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) INTERNATIONAL AFFAIRS Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ERNEST L'HERAULT VICTORIA TESSIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 520, ROCK HALL, MD 21661 EDWARD BEEKMAN/NEPHEW Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8-24-2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEÉR ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 years **Physician** EMPHYSEMA /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ certificete hes been signi rector, page 2 should be DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown ADVANCED Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) eq. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU04158 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELEN A. NOBLE, M.D., 122 SPEER ROAD, CHESTERTOWN, MD 21620 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2006 > Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificat	e of Death		3. No. 200	6 2854
Physicia Medical Exami		Decedent's Name (First, Middle, Last)     GEORGE LANGLEY CON			August 21,	Day Year 2006	3. Time of Death 2009 hrs
	,	4a Facility Name (if not institution, give street an 9545 Chantilly Farm Lane	d number)	4b. City, Town, or Location of De Chestertown	ath	4c County of Death Kent	
Funeral Director		5. Social Security Number 6. Sex 579–52–9019 1 X M 2	7. Age (In yrs. last birthd	"	8. Date of Birth OCT . 12	n(MM/DD/YYYY) 9. Birt Foreig	hplace (State or "WASHINGTON"
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a State 10b. County	10c. City, Town or		-	, , , , , , , , , , , , , , , , , , , ,	10d Inside City Limits 1 Yes 2 X No
faryland 8a-f shor at once.	Director	MD KENT  10e. Street and Number	CHESTI	10f. Zip Code	100	g. Citizen of What Coun	
ith the M 23a or 2 notified		9545 CHANTILLY FARM	LANE	21620		USA	
ter death wi ", or items er must be	by Funeral	1 X Never Married 2 Married 1 X Y 3 Widowed 4 Divorced If Yes, Given on Dates.	ed Forces? es 2 No e Year 1942-1967	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)  1 Yes 2 No specify:	rto Rican, etc.)	14. Race - Americ White, etc.	
		15. Decedent's Education (Specify only highest Elementary/Secondary (0-12)  Colle		cedent's Usual Occupation (Give kind ring most of working life. DO NOT use		16b. Kind of Business/Ir	ndustry
5-0036 led within 72 tygiene other than "the Medical I	Completed	12		COL. USAF		MILITARY/	AIR FORCE
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) GEORGE LANGLEY CONNE		THE		KNOWN''	
MD 21 nd 2 should I salth and Mer on 27 is mar	2	19a. Informant's Name/Relationship (Type, Print DANIEL P. BUCK/ PER. 20a. Method of Disposition	REP. 63	Mailing Address (Street and Number of 33 GENOA RD., TRA	CYS LANDII		9
Baltimore, MD 21215-00 pernit Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Ma		Burial 2 X Cremation 3 Remove     Donation 5 Other Specify:     Signature of Funeral Service Licensee		AKE CREMATION 8	-24 <b>-</b> 2006	STEVENSVII	
Bal permi Depar Impo injur		21. Signature of Funeral Service Licensee		22. Name and Address of Facility FELLOWS, HELFENBEI 130 SPEER ROAD,	N & NEWNA	M FUNERAL I	HOME, P.A.
Physician Wedical	4	Msa. Part I. Enter the disease, or complications the failure. List only one cause on each line.		enter the mode of dying, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner			clerotic Cardiovascula as a consequence of):	r Disease			Death
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):				
~9	miner	cause Enter Underlying Cause (Disease or injury that initiated					
executed an and al - transit	Exa	events resulting in death) Last Due to (or d.	as a consequence of):				
6) 177 177	dica	UNPENDED AMEND	ED				
8760, tificate be ng physici as the buri	n/Me	23b Was decedent pregnant in the	res, outcome of pregnancy	Fetal death 3 Ectopic pre	anancy	23d. Date of delivery Month D	ay Year
	Physician/Medical	past 12 months?	regnant at time of death 5	Other (Specify)	grianicy	MOINT	ау төаг
P.O.	þ	Part II. Other significant conditions contribution	ng to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to t	
ords w requi	ompleted				24a Was ar autopsy		opsy findings available ompletion of cause of
Recc The lar cate ha	Com				perform 1 <b>V</b> Yes 2	ned? death?	
ital lician:	B	25 Was case referred to medical examiner? Hospital:		26 Place of Death (Che			
n of Viding Phys	ا ا	1 ✓ Yes 2 No		patient 3 DOA Other 4 Nur ne of Injury 28c. Injury at Work?		esidence 6  Other:	Scene
	ation	1 Natural 5 Pending 2 Accident Investigation	Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law requir ours after death.  reral Director: After this certificate has been sfilled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Spe		n, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and <b>N</b> umber or Rur ate)	al Route Number, City
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.	Medical C	one) 2 Medical Examiner: On the ba		occurred at the time, date and place, a estigation, in my opinion, death occurre			
F 5 F 6	ž	29b. Signature and title of certifier	11/1	29c. License number		29d. Date signed (Mon	th, Day, Year)
36		JI KUVI		O.C.M.E.		August 22, 2006	
+ +		30. Name and address of person who completed Susan Hogan MD. Assistant Me	, ,	Penn Street, Baltimore, MD	21201		
St	State 31. Date filed (Month, Day, Year) 32. Register's Signature  Registrar AUG 2 5 2006						
- I regist	بلند	MUG & J LUUU	purpose of the				

		_	For State Registrer	State of I	Maryland / Dep <i>Ce</i>	artment of F			0 0 2 <sub>g, N</sub>	6 28542
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Death Month	Day Y	3. Time of Death
*	Physici /Medic		Martha M. Colgr	ove				August 2	5, 2006	1:20 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De	ath	4c. County of	
			12908 Little Hayd			Hagers		re O Data of Bigh	Washin	<u> </u>
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral		5. Social Security Number 6. Security 1	9X □M 2 🔀 F   7.	Age (In yrs. last birthday 97 Yrs.	Months Days	Hours M	in. (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		97			March 31,	1909 IV.	aryland
	and is		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man,	ţ	MD Washing	ton	Hagersto	wn				1 ☐ Yes 2 ☑ No
	r 288	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
	th wit	Funeral Director	12908 Little Hayd	en Circl	e	21742		1	USA	
	dea	ner	11. Maritaf Status	12. Was Decede	ent Ever in U.S. 13	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
98	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2: If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
00	72 hours after death with the Maryland neturel; or Iteme 23a or 28a-f ehow Jical Exantrat for notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Date		adanta Haral Ossua	ntion		Ch Kind of Buois	
215-0036	n 72	Completed	15. Decedent's Ec (Specify onfy highest gra	de completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of v	working	6b. Kind of Busin	less/industry
212	withi Bene.	mc d	Elementary/Secondary (0-12)	College (1-4		istrative	Office	r	National	Park Service
<b>d</b> 2	Hygi Hygi other		12th 17. Father's Name (First, Middle, Last)		p Miller	IDULAULVE		lame (First, Middle, M		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 Is marked other then "neturel", or Iteme 23s or 28s-f show then traumatic event, the Medical Exactical rotatics notified at	To Be	Howard McPherson	Glass			Bess	ie Free Sw	artsbaug	rh
ary	shot and N		19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ing Address (Street	and Number or	Rural Route Number,	City or Town, Sta	ate, Zip Code)
Σ	and 2 alth a 127 l		Keith M. Hoffman	/ Great	Nephew 1252	Barksdal	e Dr. L			
ore	of He		20a. Method of Disposition 1 → Buriaf 2 ☐ Cremation 3 ☐	Removal from St	20b. Place of Disp cemetery, co	osition (Name of ematory or other plac	оө)	Date 2	20c. Location - Cit	ty or Town, State
Ĕ	Pag nent ant: h		4 Donation 5 Other (Specific		Mountain	View Cemeter	7 1 0	. 29, 2006 S		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", eny injury or other traumatic event, the Medical Exagnos.		21. Signature of Funeral Service Licen	is set				erald N. M . Hagersto		uneral Home
r			23a. Part1. Enter the disease, or com	plications that cau	sed the death. Do not e					Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	1		ading	100 +74	4		fnterval Between Onset and Death
	/Medical		disease or condition resulting in death)	d	as a consequence of):	ardiomy	agrici o	+		20 gas.
	Examiner			b				9		
	7 =	Пег	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
	ocuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
30,	ate be executed nysicien and he burial-transit		resulting in death) cast	Due to (or	as a consequence of):					
8760,	ate hys	Completed by Physician/Medical	•	d						
9 ×	eath certificate ettending phys for use as the	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy		. /.		23d. Date of	oteriotisko.
Вох	ath	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 🗌 Fetal death 3	☐ Other (specify) _	MA		Mont*	Year Year
P.O.	0 0	ysic	1 ☐ Yes → No 9 ☐ Unknown	9☐ Unknow						/
	requires that the de een signed by the a nould be detached	P P	Part II. Dther significant conditions of	ontributing to dea	th but not resulting in the	underlying cause giv	ven in Part f.	23e. Did tob	acco use contrib	ute to the cause of death?
ds.	uires Sigr	D	renal for	ilare				1 ☐ Ye	s No 3	Probably 4 Unknown
00	> 0 70	lete	U					24a. Was ar	24b. We	re autopsy findings available
Re	9 7 9	E C						- autops perform 1 ☐ Yes 2	ned? dea	or to completion of cause of th? Yes 24 No
tal	iician: Th certificete rector, pag	0	25. Was case referred to medical				26. Place of I	Death (Check only one		100 270
<u>&gt;</u>		To B	examiner? 1 Yes 2 17 No	Hospital: 1 🗆 Ing	patient 2 ER/Outpati	ent 3 DOA Ott	ner: 4 🗌 Nursin	g Home 5 Reside	nce 6 Other	(Specify)
0	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of (Month)	Injury Day Year) 28b. Time Injury	of 28c. Injur	ry at	28d. Describe ho		
<u>o</u> io		atic	2 Accident investigation		X .	X	Yes 2 No		K	
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place 0	f Injury - At home, farm, s p, etc. (Specify)	treet, factory, office		28f. Location (Sta City or Town	reet and Number	or Rural Route Number,
Ω	urs af				P()*				NA	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical			est of my knowledge, de is of examination and/or or stated.					
	To the within 2 To the comple	₩.	29b. Signature and title of certifier		in	29c. Licens	se number	25	9d. Date signed (	Month, Day, Year)
	F > F 0		Dan Ma	Dougal		D	2147	0	8/28/8	06
			30. Name and address of person who	completed cause	of death (Item 23a) (Type				1	PAGERSTOWN
9	4-10		PAN MCDUNG	GAL M.D		MEDIZA	L CAM	PUS DR, S	WIF 2	29 21742
16	St	ate	31. Date filed (Month, Day, Year)	32. Re	istrar's Signature	1 .		1		
	Regist	rar	AUG 28	2005	new J. s	Joseph				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 28543 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 26, 2006 Elbert Dorsey, Jr. August 5:15 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Yrs. Director 217-42-3257 61 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo St. Mary's Hollywood Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rthen "naturel", or items 23a or the Medical Examinar must be 20636 43397 Clarks Landing Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No
If Yes, Give
Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Right of Way Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12 Foreman permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked other eny injury or other traumatic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Elbert Dorsey, Sr. Amy McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Boyce / Son 43395 Karen Court, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 8-31-2006 Hollywood, Maryland 21. Signature String Licensee
Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Koad, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Man with Brain Metartaris **Physician** 2 Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list curuitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: Al 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 29a. Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 ho To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. SC Gaby D54346 8/26/06 6 R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandra B. Sajja, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygien ?

)	28544
	3. Time of Death

			1 State		<b>,</b>	Certificate of	Death	, ,	Reg. No.			
	- A - H		Registrar  1. Decedent's Name (First, Middle, Las	=()		- Continuate of	Doutin	2. Date of Dea		3. Time of Death		
	Physici	an			т			Month	Day Year			
	/Medic		JAMES PRESTON		1			August	26, 2006 4c. County of De	9:17pm M		
VI.	Examin	er	4a. Facility Name (If not institution, give	street and number)			or Location of Death			101		
B <sub>K</sub> .			CIVISTA Medical		- (to to at bird	La Pla	ta r If Under 24 Hrs.	8. Date of Birth	Charles	rthplace (State or Foreign		
1	Funeral		5. Social Security Number 6. S	ex DXM 2□F	e (In yrs. last birt	Months Days		(Month, Day	, Year)	Country)		
	Director		219-34-9768		70			APRIL	21,1986	MARYLAND		
	and		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
	Aaryl Feho	ō	MARYLAND CHARI	ES	LA P	LATA				1XXes 2 No		
	28a-	Director	10e. Street and Number			10f. Zip Code		1 .	10g. Citizen of What C	Quntry?		
	within 72 hours after death with the Maryland ene. than 'naturel', or iteme 23e or 28e-f ehow 'ta Madical Examinar must be notified at			T 17 TO			0646		U.S.A.	,		
	eath	Funeral	#1 MAGNOLIA DRI	12. Was Decedent I	Ever in U.S.			acify Yes or No-		enican Indian.		
	ier d	n.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X			Hispanic Origin? (Spe ban, Mexican, Puerto	Rican, etc.)	Black, Wh			
36	rs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	***	1 ☐ Yes ŽŒNo	Specify:		Specify:	LACK		
Ş	hou		15. Decedent's Ed		16a.	Decedent's Usual Occu	upation		16b. Kind of Busines			
5	in 72	Completed	(Specify only highest gra	ide completed)	- ,	(Give kind of work done life. DO NOT use retir	e during most of works ed)	ng	LAN CHITNICH	ION DOCE		
en <b>2</b>	with lene.	mo	Elementary/Secondary (0-12)	College (1-4or 5		USTODIAN			WASHINGT NEWSPAPE	R POST		
Edel	Hyginther Hyginther Inthe		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,				
B au	d be ental	o Be	T.FO T.ORENZO EI	ELEN			MARY JA	NNIE F	REDERICK			
S 2	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. is marked other than "naturel", or iteme 23a or 28a-f show is marked other than "naturel", or iteme 23a or 28a-f show cumatic event. It a Madical Examinar must be notified at	F	19a. Informant's Name/Relationship (		19b.	Mailing Address (Stree	1	<del></del>				
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J	1 and Health em 27		ELLA CAMPBELL -  20a. Method of Disposition	-SISTER	20b. Place of	Disposition (Name of		Date	20c. Location - City of			
و	Pages nent of I int: if it		XXBurial 2 ☐ Cremation 3 ☐		l	y, crematory`or other pl	1	0 7 00		,		
J <sub>a</sub> Baltimore,	t. Partment		4 □Donation 5 □ Other (Specifical Service Licer			TIUS CHUE		9-1-06	CHAPEL	PT., MD		
Bal	Departit. Departitmport		21. Signature of Parietal Service Licel	The state of the s	00479	RAYMOND	FUNERAL					
			23a. Part 1. Enter the disease, or com	aliantiana that autor	d the death. Do	LA PLATA	MARYLA	ND 206	46	Approximate		
			shock, or heart failure. List only	one cause or each lin	ne.	t and the mode of cy	ying, such as cardiac c	n respiratory an	-	Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition	a. PNE	umor	JI A			FE	W DAYS		
~	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):				- F.M. 683		
	Examine:	L	Sequentially list conditions,	b		- A) .						
	pe iis	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	or):						
V	sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to force	a consequence	of):						
90,	oe ex			Due to (or as	a consequence	01).						
68760	Jeath certificate b attending physic for use as the b	Medical		_ d								
	ing p	Me	IF FEMALE:	00- 16	-1							
30,	ath c	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ісу		23d. Date of d Month	elivery Day Year		
<u>.</u>	e de the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5 ☐ Other (specify)						
Division of Vital Records, P.O. Box	that the death celled by the attendite of the attendite of the attendite of the the other than t	Physician/	Part II. Other significant conditions	contabuting to death h	out not reculting in	the underlying causes	awan in Part I	23e Did to	shacco use contribute	to the cause of death?		
Ś	signed I	Ď	CARCINOMA	20 SA		i (ile underlying cause c	giverent Fait.			Probably 4 Unknown		
ord	w requir been si should	Completed by	CARCINOMIN	11703	7777				65 20110 00	Tobaci, Jackiniom		
ပ္	e law I has by	pie						24a. Was autop	sy prior to	autopsy findings available completion of cause of		
ж.	The ate h page	NO.							rmed? death' 2 <b>X</b> No 1 ☐ Ye	? es 2□No		
ta	ian: rtifica	Bec	25. Was case referred to medical examiner?				26. Place of Deat	h Check only o	nel			
>	ysic is ce direc	ToE	1 ☐ Yes 2 No	Hospital: 1 npatie	ent 2 ER/Ou	itpatient 3 DOA	ther: 4 Nursing Ho	me 5 Resid	lence 6 Other (Sp	recify)		
٥	ng Ph ter th		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b.	Time of 28c. In piury W	ury at fork?	28d. Describe h	low injury occurred			
. <u>5</u>	ttendir death. ctor: Af / the fu	atic	2 Accident investigation	n			□Yes 2□No					
<u> </u>	er de	E E	3 Suicide 6 Could not be determined	286. Place of m	jury - At home, fa tc. (Specify)	rm, street, factory, offic	θ	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,		
Ö	rs after al Director	Certification:										
	the Hospitel or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and npietely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledge	a, death occurred at the door investigation, in my	time, date and place,	and due to the	cause(s) and manner	as stated.		
	he H in 24 he F plete	edicai	one)	and manner st	ated.	CO INVESTIGATION, IN TH	opinon, dean occur					
	OOK VITAL AND THE PROPERTY OF				29c. Lice	nse number	1	29d. Date signed (Mo				
			// Lgam	1		D-4	4436		Angust	27 2006		
	0.	-	30. Name an address of person who	completed cause of	death (Item 23a)	(Type, Print)			O			
	7		Dr. Ashvin J. Pat	el. MD. F	aul Mel	lon Court,	Suito 102.	Walder	f_MD 20603	-2793		
State 31. Date filed (Month, Day, Year) 32				32 Tegistr	rar's Signature	Souli						
R	Regist	rar	SEP 0 8 20	Ub CONCA	N D.	Goods						

		•	For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of H rtificate of		Mental Hygi	ene g. No. 2006	28545
	Physici	20	1. Decedent's Name (First, Middle	a, Last)				2. Date of Death	Day Year	3. Time of Death
	/Medic		Anna	Mae	Egan	I		SEPTEMBE	R 1 2006	
	Examin	er	4a. Facility Name (If not institution MEMORIAL HOSPI)				r Location of Deat ERLAND	h	4c. County of Dea	
	Funeral Director		5. Social Security Number 220-10-7306	1 🗆 M 2 🗆 E	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month, Day, Mar 2,	1910 9. Bir	hplace (State or Foreign puntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tor	MD Alle	gany	Cum	berland				1 X Yes 2 □ No
	th the	lirec	10e. Street and Number		·	10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	raic	212 Arch Stree				21502		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 le marked other than "naturel", or teme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Yes, Give X	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗷 No	dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
8	sture!	ed b	15. Deceder	t's Education	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business	
215	Thin 72	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5+	)	kind of work done DO NOT use retire	during most of wo d)	rking		,
7	led wii ygien her th		12		Home	maker	40.44.4.4.4.4		Own Home	
Maryland 21215-0036	uld be fil Mental H irked ott	To Be	17. Father's Name (First, Middle, William Bard					ne (First, Middle, M		
Man	nd 2 sho alth and i 27 le mu or traumu		19a. Informant's Name/Relations Nora Collett	hip <i>(Турө, Print)</i> daugl	nter P.C	ng Address (Street ). Box 547	and Number or Re Bridge F	aral Route Number, Rd. Fort A	City or Town, State, . Shby V	VV <b>2</b> 6719
Baltimore,	Pages 1 e ent of He nt: If Item ry or othe	13.	20a. Method of Disposition 1 ☐ Burial 2 ☐ &remation 4 ☐ Donation 5 ☐ Other (5		20b. Place of Dispo cemetery, crea Scarpelli F	osition (Name of matory or other pla uneral Hom	<sub>се)</sub> e, Р.А.	9/2/2006	Oc. Location - City or Cresaptow	
Balti	permit. P Departm Importar any injur		21. Signature of Funeral Service		1/1 2	2. Name and Addre	III Funeral I	Home, PA		
			23a. Part 1. Enter the disease, or	complications that caused the		ter the mode of dyn	ng, such as cardia		and, MD 215 st.	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	only one cause on each line $ASP$	RATION	PNEN	MONIA			Onset and Death
	/Medical Examiner		resulting in death)	a	consequence of):					0-3
	LAGITITICI	-	Sequentially list conditions,	b	сопредпечения об.					Q
1	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,	cate be executed physicien and the burial-transit	i Exa	resulting in death) Last	Due to (or as a	consequence of):					
3876	cate b physic s the b	dical		d						
9 X	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75			23d. Date of de	ivery
Division of Vital Records, P.O. Box	Attending Physician; The law requires that the death certificate be executed to death. The death.  ector: Attenthis certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown		⊒Ectopic pregnanc ☐ Other (specify) _	<b>y</b>		Month	Day Year
۳.	s that the need by a detact	by Ph	Part II. Other significant conditi		not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ords	w requires to been signer should be	led b	LUNG N	ASS				1 ☐ Ye	s 21520No 3□P	obably 4 Unknown
Seconomic Secono	The law roote has be page 2 sh	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
a	ician; Thi certificete rector, pag		, 05 W					1□ Yes 2	XLNo 1 ☐ Yes	2 No
₹ ;	ysician; iis certific director,	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 11⊠npatien	t 2 ER/Outpatier	nt 3C DOA Ott	000	ath (Check only one	nce 6 □Other (Spe	City
יס כ	ng Phys ter this neral di	T;T	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe ho		city)
Sio	tendir eath. ior: Al the fur	catic		gation	,,		Yes 2 □ No			
	lor At after d Direct In by	Certification;	4 Homicide determ		y - At home, farm, st (Specity)	reet, factory, office		28f. Location (Str City or Town,	eet and Number or R. , State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Aller th completely filled in by the funeral	ca	(Check only 21 1 Medical	ng Physician: To the best of Examiner: On the basis of e	examination and/or in	westination in my o	nining death occu	irred at the time, da	to and place, and dru	to the causals)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifie	and manner state	9G.	29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
)	⊢ ≯ ⊢ ŏ	3	•	H. Chotan	~	DS	78853		9/1/0	6
	5	1	29b. Signature and title of certifies  30. Name and address of person HAGIB CHC  31. Date filed (Month, Day, Year, SEP 0	who completed cause of dea	ath (Item 23a) (Type,	Print) SYLVAN	VIA AV	E, Cun	1BERLAN	UD, MD
	Sta Regista	ite ar	31. Date filed (Month, Day, Year, SEP 0	8 2006 32. Redistrar	's Signature	book				

			1 = For State Registrar	e of Maryland		rtment of H			ene	2051.6		
1	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death		
	/Medic Examir		Thomas James Eng  4a. Facility Name (If not institution, give street au  5801 Pontiac Str	nd number)		4b. City, Town, or	Location of Dec		18, 2006  4c. County of Death  Prince (	leorge's		
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 E	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	0	s. 8. Date of Birth	Year) 9. Birthp	place (State or Foreign ptry) nnessee		
	Ba-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Geor	ge's Be		Heights				0d. Inside City Limits 1 ⊠ Yes 2 □ No		
	ne 23a or 2 must ke n	Funerai Dir	5801         Pontiac         Street           11. Marital Status         12. Was	Decedent Ever in U.S.	13. V		20740	Specify Yes or No-	g. Citizen of What Cour  U.S.A	Α.		
036	ours after d at', or item Examiner	ğ	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2 [X] No es, Give r or Dates:	l1	Yes, specify Cuba	Specify:	rto Rican, etc.)	Black, White,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show amy proportant: if item 27 is marked other than "natural", or items 23s or 28s-f show amy injury or other traumatic event, the Mindical Examinar must be inclined at ances.	Completed	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) Coll	eted) ege (1-4or 5+)	(Give i life. [	lent's Usual Occupa kind of work done of DO NOT use retired, Coordinato	luring most of w )	orking	tking 16b. Kind of Business/Industry University of Shman English Maryland			
yland 2	ould be filed Mental Hyg warked other	To Be C	17. Father's Name (First, Middle, Last)  Wesley Thomas Eng	ram			18. Mother's N	ene Edith	aiden Sumame) Unknown			
re, Mar	Health and the tem 27 is mother traum		19a. Informant's Name/Relationship (Type, Prin Jonathan Engram — Br 20a. Method of Disposition	other 20b. Place	2848 of Dispos	Kensingt	on Road	, Winston-	City or Town, State, Zip Salem, NC 2 Oc. Location - City or To	27106		
Baltimore,	permit. Pages Department of Important: If i any injury or o		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	from State	Linco	natory or other place In Cemeter . Name and Addres	y 08		Brentwood, neral Home,	•		
ă	8 3 E 8		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. De on each line.					ttsville, N	Approximate Interval Between		
1	Physician /Medical Examiner			ue to (or as a consequenc	ce of):			ARRYTI TERV I	YMIA DISEASE	Onset and Death		
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Vital Records,	ysician: The law re is certificete has be director, page 2 sho	Completed						24a. Was an autopsy perform 1 Yes 2	prior to cor	osy findings available inpletion of cause of		
<u> </u>	rsician: Th s certificete lirector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospitat:	1 ☐ Inpatient 2 ☐ ER/	Outpation	3 DOA Othe		Homo F Rosidos	) ace 6 □Other (Specify	A		
Division of	Attending Physician: r death. ector: After this certifice by the funeral director, p	ation; To	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation		o. Time of Injury	28c. Injury Work		28d. Describe how		7		
N N	Dia	Certification	4   Homicide	Place of Injury - At home, building, etc. (Specify)				City or Town,				
	To the Hospital within 24 hours To the Funeral completely filled	Medicai	10	To the best of my knowled the basis of examination manner stated.	dge, death and/or inv	estigation, in my op	inion, death oc	curred at the time, dat	e and place, and due to	the cause(s)		
•	() ()		29b. Signature and the of contribility			D2	000		d. Date signed (Month, )	51,2006		
R	(3)		10.012	BE RD,	COL	-LEGE	PAR	CK MD	20740			
	Sta Registr		AUG 2 4 2006	2. Registrar's Signature	Local	w			/			

State of Maryland / Department of Health and Mental Hygien 2006 28547 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ralph Junior Fisher 10:01A M September 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 28 Blue Mountain Estates Washington Smithsburg If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 1929 Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Hours Yrs. Director 77 220-26-7460 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov the Modical Examiline most be notified at Completed by Funeral Director 1X Yes 2 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Blue Mountain Estates 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 X Divorced White . 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Mason Concrete other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Emory Fisher 2 Cora Mae Earley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Wetzel (Grandson) 14350 Brown Road Sabillasville, Maryland 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Mo/4/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 avis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Obstructive Pulsion on disease or condition resulting in death) 2040s /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Cher (specify) P.O. 1 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. cate has been signe, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☑ No 1 Yes After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the neground within 24 hours after death.

To the Funeral Director: After the funeral by the fur death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/5/06 4 1 Hollis D 43280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Kevin E. Hohlas 31. Date filed (Month, Day, Year)

SEP 0 8 2006

300 S. Church St. Mildle town md 21769

32. egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

SEP 0.8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 28549 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 17, 2006 **Physician** Leon Edgar Fletcher 12:40 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Mariner Health Care of Greater Laurel Laurel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/8/26 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F Days **Funeral** Months Maryland Director 219-16-1486 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Modical Exertiner used be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√2 Yes 2□No **Funeral Director** Lanham P.G. Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 14200 Laurel Park Drive 20707 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. African-American 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Car Wash Manager 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Deal Walter Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7916 Cawker Ave., Lanham, Maryland 20706 Florence Fletcher/Wife 8/25/06<sup>20c.</sup> Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Washington, D.C. Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22, Name and Address of Facility</sup> & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 anu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical End Stage Liver Disease 1 Year Examiner Due to (or as a consequence of) Examiner 6 Months sician and burial-transit b. Severe Pancytopenia requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of) attending physician for use as the burial 2 Years End Stage Renal Disease Division of Vital Records, P.O. Box 68760, Physiclan/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 3 Weeks Septicemia 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached the 1 Yes 2 No 3 Probably 4 Unknown Severe Erosive Gastritis þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Gastric Ulcer 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ဥ After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours efter death. To the Funerel Director: After it completely filled in by the funera 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ATTEN DING D0057216 August 21, 2006 and on the PITYSILIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3458 Fort Meade Road, Suite 209

Laurel, MD 20724

M.D.

2. Registrar's Signature

Michael Baako,

AUG 2 3 2006

31. Date filed (Month, Day, Year)

Registrar

State

			1 - For State Registrar	State of M	arylan				ealth a	and M	ental Hy	giene,	2006	28550
Ų.	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De	eath Day	Year	3. Time of Death
1	/Medi		RUTH		FREDI	ERICK					AUG.	22,	2006	5:20 A M
	Examir	er	4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location of	of Death		1	ounty of Deat	
3-1		ş.	HILLHAVEN No. 5. Social Security Number 6. S			last birthday)	If I lode	ADEL:	PHI If Under:	24 Hrs	8. Date of Bit		INCE GI	
	Funeral Director		,	1 □ M 2 X F	84	Yrs.	Months		Hours	Min.	(Month, Da	ay, Year)	21 FT	hplace (State or Foreign untry) LORIDA
			Usual Residence of Decedent		. 04		1				DEL I.	3,17	ZI FI	JORIDA
	nylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	8a-f	cto	MD. PRINCE	GEORGES			-1	ENBEL'	Τ					1 ☐ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number				10f. Z	p Code	_			10g. Citiz	en of What Co	,
	eath is 23,	erai	3-A EASTWAY  11. Marital Status	RD.	Supr in 11	S 12	Was Door	207		nin? (Sna	oilu Vac or Ne	1.	U.S.A.	
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036	ours a	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2X No	Specify:			5	Specify: V	VHITE
21215-0036	be filed within 72 hours after death with the Maryland hat hygiene. Id other than "natural", or Itams 23a or 28a-f show event, if a Medical Exercities from the trutified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usi	al Occupa	ition uring most	of working	na	16b. Kin	d of Business/	industry
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	e filed within al Hygiene. other than vent, it e Me		12 17. Father's Name (First, Middle, Last	1			HON	IEMAK:		r's Name	(First, Middle	Maiden	HOME	
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Maryland	should be nd Mental marked (	၉	19a. Informant's Name/Relationship (		ON	19b. Maili	ng Addres	s (Street a	and Numbe				Town, State, 2	Tip Code)
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ğ.	item item		20a. Method of Disposition	-	20b. F	Place of Dispo	sition (Na	me of			ate		ation - City or	Town, State
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic events of the process.		21. Signature of Funeral Service Lice	See A	7	Č.	2. Name a HAMBI	nd Addres	s of Facilit	L HOI	ΜΕ & CI	REMAT	ORIUM,	P. A.
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	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MULTILO  Due to (or as	ne. BAR I a conseq	PNEUMOI uence of):								Approximate Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as							1-1-6			
P.O. Box 6	ires that the death certifica signed by the ettending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3[	]Ectopic p ] Other (s					23	d. Date of deli Month	very Day Year
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la	ificate or, pa	e Co	25. Was case referred to medical						00 Bl	-4 D45	1 Tes	2 X No		2 No
>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆	ER/Outpatier	nt 3[] []	OA Othe			(Check only o		Other (Spec	2461
Division of Vital	Attending Phir death. ector: After thi		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury Work		2	8d. Describe			
Divis	P Sirie	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ury - At ho c. (Specif	ome, farm, str	eet, facto	y, office		2	8f. Location (. City or To		Number or Ru	ral Route Number,
	ne Hospital n 24 hours a ne Funeral to bletely filled	edical (	29a. Certifier (Check only one)	nysician: To the best niner: On the basis o and manner sl	fexamina	wledge, death tion and/or in	h occurred vestigation	at the tim	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To ti Comp	ž	29b. Signature and title of certifier	11			29	c. License	number			29d. Date	signed (Month	, Day, Year)
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-		10	THOMAS E. MASS						NTER :	DK.,	F316, (	KEEN]	BELT, M	D. 20770
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	Physicia		Decedent's Name (First, Middle     JANETTE	MARIE	F	FIELDS	S-BARNES		2. Date of Dear Month	th	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution			al	4b. City, Town, or	Location of Death	in agos s	4c. County of E	
H	Funeral Director		5. Social Security Number 204 – 46 – 9628	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. 51		If Under 1 Year Months Days		8. Date of Birth (Month, Day April	0	Birthplace (State or Foreign Country) ennsylvania
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wash	nington		y, Town or Lo Hagers					10d. Inside City Limits 1 □X'es 2 □ No
	with the last or 28a-	Direct	10e. Street and Number 971 Noland			3	10f. Zip Code 21746	า	1	0g. Citizen of Wha	-
0	after death or Items 23	Funeral Director	11. Marital Status 1 □ Never Married 2 🂢 Mar	12. Was Dec	2X No			ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - / Black, V	American Indian, White, etc.
200-01	"natural",	leted by		Year or I nt's Education est grade completed	Dates:	16a. Deced	dent's Usual Occup	ation during most of work	ing	16b. Kind of Busin	Black  ess/industry  Administration
717 D	filed within Hygiene. other then ent, It e M	e Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle,	7	(1-4or 5+)			t Specia		Medical	
ar ylalla	should be nd Mental marked o	To B	Samuel  19a. Informant's Name/Relations	Eddi ship (Type, Print)	e	Field		There		Mary ; City or Town, Sta	Young ate, Zip Code)
ore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If it item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, it a Marical Examinating must be natified at once.		Paul L.R. Ba  20a. Method of Disposition  1 Disposition  2 Cremation		State	Place of Dispo cemetery, crem	sition (Name of natory or other plac	se)	Date	, Marylar 20c. Location - City	y or Town, State
Dalkillio	permit. Pag Department Importent: any injury c		'4 □Donation 5 □Other (5	Specify) Licensee	Whit -	22	Memorial Name and Addre	ss of Facility			ennsylvania
	Physician	Š.	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition			h. Do not ent	East Ant er the mode of dyin dia Arry	g, such as cardiac	reet, Ha	gerstown,	Approximate Interval Between Onset and Death
,0070	/Medical Examiner  bhysician and sthe burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. H Due to	(or as a conseq	nsive	Heart (				3 yrs.
O. BOX 60	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of co nown	ıl death 3□	Ectopic pregnancy	,		23d. Date of Month	f delivery Day Year
ds, r.	quires that t n signed by ald be detac	d by Physi	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tol		ite to the cause of death?  Probably 4 Unknown
Records,	sicien: The law rec certificate has beel irector, page 2 shou	Completed							24a. Was a autops perfor	med? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
VISION OF VITAL	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification: To Be (	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Qould	Hospital: 1 = 28a. Date (Mo	of Injury nth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor M 1	4   Nursing Ho	ome 5 Reside	ence 6 Other (	
200	spitel or At lours after of neral Direct filled in by		4 Homicide deter	mined 286. Plac	ding, etc. (Specia	fy) 	eet, factory, office	ne, date and place,	City or Town	n, State)	or Rural Route Number,
	o the Ho vithin 24 h o the Fur	Medical	(Check only one)  2 Medice 29b. Signature and title of certifit	and ma	basis of examina nner stated.	ation and/or in	vestigation, in my o			ate and place, and 9d. Date signed (M	er as stated. I due to the cause(s)  Month, Day, Year)
	⊢ s ⊢ ŏ		30. Name and address of person	1017 - On Official and contribution	ise of death (ti-	n 23a) /T. ac		28656		August	28, 2006
5	4-3	ato	Ravi Pas	si, M.D.		Shad		Road, #	208,	Rockvil	le, Md. 2091
	Sta Registr		31. Date filed (Month Parcy eg	0 2000	Bellen	13. P	PRINCE				

	•		1 - For State Registrar	State of Ma	aryland		artment of Hea <i>rtificate of De</i>		, ,	ene g. No. 200	16 2	8552		
	Physici		Decedent's Name (First, Middle,  Susan	Last) Patrici	а		Gable		2. Date of Death	Day Y	3. Ti	ime of Death		
	/Medi Examir		4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, or Loc	cation of Death	Hugust	4c. County of I	Death	7 00 11		
		Ų	Washington Coun  5. Social Security Number 6		e (In yrs. last	t hirthday)	Hagerstov	VIII Under 24 Hrs.	8. Date of Birth	Washi		Chata as Essaia		
ŀ	Funeral Director		219-54-0548	1□M 2X F	56	Yrs.		ours Min.	Month, Day, Sept. 21	Year) 1949 D:	Country)  istrict	Sgif or Foreign t Columbi		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation					side City Limits		
	Maryl	tor	MD Washir	ngton		rstow						Yes 2 □ No		
	or 284	Direc	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	-			
	eath w	Funeral Director	848 Spruce St.	12. Was Decedent I	Ever in LLS	13 \	21740	nic Origin? (Sr	pacifu Vos or No	U.S.A.	American Indi	lian		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, it a Medical Exaction mind to relified at angle.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?			Was Decedent of Hispa f Yes, specify Cuban, M I □ Yes 2ሺ No Si	nic Origin? (3) lexican, Puerto pecify:	Rican, etc.)	Black, \	White, etc. White	idii,		
5-0	"natur	eted	15. Decedent's (Specify only highest)	Education grade completed)	1	(Give	tent's Usual Occupation		ung 1	6b. Kind of Busin	ess/Industry			
72	withir liene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Arti	OO NOT use retired)			The Fine	Arts			
<b>Maryland 21215-0036</b>	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, La		-				e (First, Middle, M	,				
돌	d Men marke matic	2	Joseph Newcomer  19a. Informant's Name/Relationship			105 14-85	g Address (Street and I		ose Walke		. 7 0 11			
	nd 2 salth an 27 is i		Erin E. Smith/Day				Cagles Ridg							
Baltimore,	Pages 1 and neut of Hei		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		20b. Place ceme	e of Dispo etery, cren	sition (Name of natory or other place) n Cemetery		Date 2	oc. Location - City		ate		
Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Lic	epsee			Name and Address of 01 Pennsyl				•	.1 !1742		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. (	Do not ent	er the mode of dying, su	uch as cardiac	or respiratory arres	st,	Interva	oximate ral Between		
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	disease or condition										
	Examiner				a consequen	ice of);								
7	p ii	iner	Sequentially list conditions, if any, leauring to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	а сольециел	ce oi):					1			
	execute n and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ce of):								
68760,	ificate be executed g physicien and as the burial-transit	edicai		d					_					
O. Box 6	requires that the death certific wen signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day	Year		
a.	ires that the signed by	þ	Part II. Other significant conditions	contributing to death bu	ut not resultin	ng in the ur	derlying cause given in	Part I.		cco use contribu				
200	> 40 70	letec							24a. Was an	-		dings available		
Vital Records,	o	Completed							autopsy perform	prior	r to completion th?	n of cause of		
V Ka	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamilton /				Place of Deat	h Check only one		103 2010			
ō	Physic r this caral dir	<u>۲</u>	1 ☐ Yes 2 ☐ No  27. Manner ef Death	Hospital: 1 1thpatie	y 28i	Outpatien			ome 5 Residen		Specify)			
<u> </u>	ttending I death. tor: After the funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day ion	Year)	Injury	28c. Injury at Work? M 1 \( \triangle \triangl			,,				
DIVISION	4	Certification:	3 Suicide 6 Could not determine	28e. Place of Inju- building, etc	ry - At home (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		r Rural Route	Number,		
	To the Hospitel or within 24 hours after For the Funeral Direction completely filled in b	Medical	29a. Certifier 1 Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the time, di estigation, in my opinion	ate and place, n, death occur	and due to the cau red at the time, dat	ise(s) and manne e and place, and	r as stated. due to the ca	iuse(s)		
	To To	Σ	29b. Signature and title of certifier	1/ -			29c. License nur		290	d. Date signed (M	- ·			
	10		30_Name and address of person wh	o completed duse of de	eath (Item 23	a) (Type. I	Crint) 236		1/4	revet a	29 2	2006		
	Ψ		Frederic 14	[CASI III	mn	1111		well	empus	a	t Lege	13 hours		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2	32 Jegistra	r's Signature	Lo	ule		4		m	. A		

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic avant, the Medical Examinest most be notified.

been signed by the should be detached

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

1 - State Registrar		C	Certific	cate of E	Death		Rag	<sub>s. No</sub> Z U	106	285	23
1. Decedent's Name (First, Mide	dle, Last)						2. Date of Death Month	Day	Vost	3. Time of D	eath
Gilbert S.	Grubowski	_					SEPTEMBI		2006	7:50 1	A. M
4a. Facility Name (If not instituti	on, give street and num	ber)	4b.	City, Town, or	Location o	of Death		4c. Cour	ity of Death		
VA MARYLAND H	EALTH CARE	SYSTEM		PE	ERRY	POIN	${f T}$		CECI	L	
5. Social Security Number		7. Age (In yrs. last birtho	Mo	Inder 1 Year	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp Coun	lace (State or	Foreign
212-26-4867	1 <b>20</b> 4M 2□ F	76 Yr	S.				Nov. 29,		Mary		
Usual Residence of Decedent  10a. State 10b. Count	tv	10c. City, Town o	or Location	1					1	0d. Inside City	Limits
MD Harfe	,	Aberde							'	1 🗌 Yes 2	
10e. Street and Number		Aberdee		f. Zip Code			10	- Citizan o	4 M/han Caus		
821 Adams Ave	enue		10	2100	1		10		f What Cour	itry :	
11. Marital Status		dent Ever in U.S.	13 Was I			nin? (Sne	ecify Yes or No-	U.S.	A. ace - Americ	an Indian	
1 ☐ Never Married 2 ☐ Ma	Amed For	ces?	If Yes	specify Cubar	, Mexican	, Puerto	Rican, etc.)		lack, White,		
3 ☐ Widowed 4 ☑ Divorce	If The Give	tes: 1951-53	1 🗆 Y	es 2XNo	Specify:			Spec	eify: Whit	:e	
	ent's Education	16a. D	ecedent's	Usual Occupa	tion		- 10		Business/Inc		
(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-		Give kınd i ife. DO N	of work done d OT use retired)	uring most	t of worki	ng				
6	0	St	ceel	Worker			1	Manuf	acturi	nq	
17. Father's Name (First, Middle	e, Last)				18. Mothe	r's Name	(First, Middle, Ma	aiden Suma	ame)		
Steven Grub	oowski				Mar	у Не	len				
19a. Informant's Name/Relation						r or Rura	il Route Number, (	City or Tow	m, State, Zip	Code)	
Manning Klepsi	rg (Nephew)	3	3116	Snake I	ane		Churchvi.	lle, 1	MD 2	1028	
20a. Method of Disposition	2 [][[amazzal fram 6	20b. Place of D cemetery,	isposition cremator	(Name of or other place	)		Date 20	oc. Location	n - City or To	wn, State	
1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		St. Sta	nisl	aus Cem	eter	v 9/	8/06 I	Baltir	nore,	Min	
21. Signature of Funeral Service	e Licensee		22 Nam	ne and Address	of Facilit	V					
1 Yana	C. Sell	man	333	South	Parke	e St	ral Home Abei	deen.	Marv	land 2	1001
a. Part1. Enter the disease, sock, or heart failure. Lis	or complications that ca	used the death. Do not								Approximate Interval Between	
Immediate Cause (Final disease or condition		ON CANCER							T	Onset and De	ath
resulting in death)	a	or as a consequence of)	):							TATATACANTA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a consequence of)									
Cause (Disease or injury that initiated events	G.										
resulting in death) Last	Due to (d	or as a consequence of)	):								
	d.										
IF FEMALE:								1	_		
23b. Was decedent pregnant		ome of pregnancy th 2 ☐ Fetal death	3 □Ector	pic pregnancy					ate of delive		
in the past 12 months? 1 ☐ Yes 2 ☐ No		int at time of death		or (specify)					Month	Day Ye	ar
9 ☐ Unknown						_	· *				
Part II. Other significant condi-	tions contributing to de	ath but not resulting in th	he underly	ing cause give	n in Part I.		23e. Did toba				
							1 ☐ Yes	2 □ No	3 🗍 Prob	ably 4 X∭Un	known
							24a. Was an autopsy	245	. Were auto	osy findings av	railable
							performe	ed? ☑ No	death?		150 01
25. Was case referred to medic	al				26. Place	of Death	Check only one				
examiner? 1 ☐ Yes 🏽 🏋 No	Hospital: 1 🔀 Ir	patient 2 ER/Outpa	atient 3[	DOA Othe	r: 4 🗆 Nu	rsing Hor	ne 5□Residen	ce 6 □O	ther (Specify	')	
27. Manner of Death 1 □ Natural 5 □ Pend	28a. Date o	Injury 28b. Tim , Day Year) Inju		28c. Injury Work			28d. Describe how				
2 ☐ Accident inves	tigation	, -=,=,	M		es 2 🗆	Vo					
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Place	of Injury - At home, farm g, etc. (Specify)	n, street, fa	actory, office			28f. Location (Stre City or Town,	et and Nun State)	nber or Rura	Route Number	er,
29a. Certifier 1 X Certify (Check only one) 2 Medical	ring Physician: To the al Examiner: On the ba and mann	sis of examination and/o	death occu or investig	urred at the time ation, in my op	e, date and inion, deat	d place, a	and due to the cau ed at the time, dat	se(s) and r e and place	manner as st a, and due to	ated. the cause(s)	
29b. Signature and title of certif	ier /			29c. License	number		290	d. Date sign	ned (Month,	Day, Year)	
1/1	11			Ι	5273	9	SI	EPTEMI	BER 2,	2006	
30. Name and address of perso	n who completed cause	of death (Item 23a) (Ty	ype, Print)	-			1 3.				
SUREŚH SHANDE				LTH CAF	RE SY	STEM	, PERRY	POINT	, MD 2	1902	
31. Date filed (Month, Day, Yea		gistrar's Signature			-						
SEP 0	8 2006	Eur H	1	0.							
		COST JO	C. 134								

Registrar

			1 - For State Registrar	State	of Maryla	-	artment of H		-	giene Reg. No. 2 () (	በፍ	28551
		п	Decedent's Name (First, Middle	, Last)					2. Date of De	ath	Year	3. Time of Death
	Physici /Medic		BONNIE LOVELLA	GREEN						ber 1, 20		5:05 P M
è	Examin		4a. Facility Name (If not institution 549 Park Manor		number)		4b. City, Town, or Bel Ai		h	4c. County o	of Death rfor	d
9	Funeval		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt			place (State or Foreign
H	Funeral Director		212-62-5627	1□M 2¬F		Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 4/9/19	y <i>Year)</i> 56	Cou	yland
-1	pu k		Usual Residence of Decedent  10a, State 10b, County		100	City, Town or Lo	cation				1.	I 0d. Inside City Limits
	Maryla f eho	ō	PA York			elta	Cation					1 ☐ Yes 2 ☑ No
	7.28e	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cou	ntry?
	death with the Maryland me 23a or 28e-f ehow		57 Watson Roa	.d			1731	.4		US	A	
	er dea	Funeral	11. Marital Status	Armed	ecedent Ever in Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)		- Ameri	can Indian, etc.
36	i 72 hours after death with the Marylan "natural", or Iteme 23a or 28e-f ehow idical Examination intellet inclined at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Year or	s 2∭No Give Dates:		1 ☐ Yes 2X No	Specify:		Specify:	В	lack
Š	72 hou	ted	15. Deceden	's Education		16a. Dece	dent's Usual Occupa	ation	atria a	16b. Kind of Bus	siness/In	dustry
2	be filed within 72 hc tal Hygiene. d other then "natur event, the Modical	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)		kind of work done of DO NOT use retired n Chief	) )	rking	Health (	aro	
2	il Hygier other th	Col	12 17. Father's Name (First, Middle,	( ast)		TITLE	ii ciitet	18 Mother's Nar	ne (First Middle	Maiden Sumame		
au	Mental I	To Be	Joshua Eugene	· .					Mae Mose		*/	
Maryland 21215-0036	should by	-	19a. Informant's Name/Relations	nip (Type, Print)		1	ng Address (Street a			er, City or Town, S	State, Zip	Code)
_	s 1 end 2 f Heeth a flem 27 la other tre		Michael G. Gr	een, Sr.	Ten		atson Roa	id, Delta	-	7314		
altimore,	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	3 □Removal fro			isition (Name of matory or other plac Jion Cemet		Date /2006	Delta,	•	own, State
Baitii	permit. Pages Department of I Importent: If It any Injury or or once.		21. Signal re of Funeral Service		0 1.	22	Name and Addres	ss of Facility	-			17314
	do se d		23a. Part1. Esperane disease, or	complications tha	t caused the	ce					17	Approximate
н	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause of	each line.	adas	4 - 0	g, 5501, 25 52.512.	o or roopiratory at			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue	(or as a cons	sequence of):	ne			·		7
	Examiner		Sequentially list conditions,	b	Diain	mel	astre					2,54
1	led set	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	O (or as a cons	sequence of):	coll 1	My CC	mcl1/			2.54
Y	execu n and ial-tra	Examine	that initiated events resulting in death) Last	c	o (or as a cons	sequence of):	CO / C		7-000			,,,,,
8760	death certificate be executed e attending physicien and id for use as the burial-transit	dicai		d								
٥	ertifica ling ph	Med	IF FEMALE:	22- #							and the second	
X Q Q	leath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pre- birth 2 F gnant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
oʻ.	by the de	Physician/Me	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□ Un								
s, J	res the signed I be det	by P	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	1.771	bute to t	ne cause of death?
ord	w require been sig should b	ted							101	res 2 No	3 Prot	pably 4 Unknown
Hecords,	e la has je 2	Completed							24a. Was autop	osy pr	ere auto for to co eath?	psy findings available mpletion of cause of
Vital		င္ပေ	25. Was case referred to medical					00 Di D	1 ☐ Yes	2,2(No 1	Yes	2 No
		To B	examiner?	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA Othe	25	ath <i>(Check only o</i> flome 5 ☐ Resid	V	r (Specif	w Harrice
n o	ng Phys fter this ineral di		27. Manner of Death 1 Natural 5 ☐ Pendin		te of Injury onth, Day Year	28b. Time o Injury	28c. Injury Work	at c?	28d. Describe h	now injury occurre	d	
Division	or Attending siter death. Diractor: After in by the fune	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	not be and Blo	oo of loive. A	t bome form at		Yes 2 □ No	79f Location /	Personal area Alexandra	O	of Courts M. on the
2	effer effer Dirac	Certification;	4 Homicide determ	ined 200. Fiz	Iding, etc. (Spe	ecify)	eet, factory, office		City or Tox	Street and Numbe vn, State)	r or Hura	in Houte Number,
	To the Hospital or Attending Ph within 24 hours elfer death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my less to basis of exame	knowledge, deat ination and/or in	occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) and man date and place, ar	ner as s	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certific		Medic	al Onco	29c. License	number		29d. Date signed	(Month,	Day, Year)
)			Xh WW H	ewww	1/		1)40	2160		4/5/	06	
	10		30 Name and address of person	who completed ca	use of death /	tem 23a) Type.	Print) The	et, Ba	ltimore	10 20	817	
	Sta Registr		31. Date filed (Month, Day, Year)	8 2006	Registrar's Si	gnature	Casti)					

			1 - State Registrar	State of Maryland		rtment of H			ene 2006	28555
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic	_	Thomas	Walter	Gerov	rac		Septembe	er 1, 2006	2:45 pmм
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
			8102 Overlook Cou	ırt		Frede			Freder	ick
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		396-36-4007	M 2UF 65	5 Yrs.			Oct 3,	1940 Wis	sconsin
	pue *	1	Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
	et e	ក	Maryland Frederi		Frede					1 Yes 2 No
	28a-1	Director	10e, Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	A A		8102 Overlook Cour	t		Ton Elp Godo	21702		U.S.A.	
	within 72 hours atter death with the Maryland ene. Then "naturel", or items 23e or 28e-f ehow the Medical Examiner mast be notified at	Funeral	11. Marital Status	2. Was Decedent Ever in U.S	S.   13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
^	Tiger of the control	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No	ĺ			Rican, etc.)	Black, Whi	te, etc.
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2XX No	Specify:		Specify:	√hite
9500-612	2 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occupa	ation	ina	16b. Kind of Business	/Industry
7	the state of	P P	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)	9	Tales and a	_
N	filed withir Hygiene. other then ent, the M	ပ်		5 +	rea	cher			Education	.1
and	be fill bd oth even	Be	17. Father's Name (First, Middle, Last)	Gerovac				e (First, Middle, M	Obiden	
	Men	ဥ	Emil				Anna			
	2 short and h is ma	8 1	19a. Informant's Name/Relationship (Typ						City or Town, State,	
_	and lealth m 27 her t		Vera T. Gerovac, W			Sition (Name of			k, Marylai	
0	Pages 1 and the nert of He int: If item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	amoval from State	metery, cren	natory or other plac	e)			
	Pa tmen tant: tant:		4 □ Donation 5 □ Other (Specify)							g, Maryland
Baltimore,	permit. Page Department of important: if eny injury or once.		21. Signature of Funeral Service License	)					neral Home	
	46.200		23a. Part1. Enter the disease, or complic	MOO706		6 East Ch	nurch St,	Frederi	ck, maryla	and 21701 Approximate
			shock, or hear failure. List only on	e cause on each line.						Interval Between Onset and Death
y 1	Physician		Immediate Cause (Final disease or condition resulting in death)	hepol	1-10	Loni	10-0			1000
	/Medical Examiner		1	Due to (or as a consequence of the second	ence of):		-/-		6 -	
		ē	Sequentially list conditions.	Due to (or as a consequence	ence on:	/21	1 450	757	2.0	-
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	exect n and ial-tra	Exa	that initiated events c resulting in death) Last	Due to (or as a consequent						-
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9	ifficat g phy as th	edi								
ROX	death certific e ettending p id for use as	2	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of de	
	0 0 0	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specify)	·		Month	Day Year
J.	at the de by the e	Physician/Me	9 Unknown	9 Unknown	1 11					
s,	requires that the seen signed by th hould be detache	þ	Part II. Other significant conditions con	tributing to death but not resul	tting in the ur	nderlying cause give	en in Part I.	1		to the cause of death?
Vital Records,	w requir been sl should I	ted						1	s 2 € No 3 □ P	robably 4 Unknown
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<u>=</u>	Physician: Th this certificate al director, pag	Be (	25. Was case referred to medical examiner?					th (Check only one	9)	
	Physician: r this certific ral director,	ē,	1 ☐ Yes Z		ER/Outpatien		4 🗆 Nursing n	ome 5 Reside	nce 6 □Other (Spe	ecify)
٠ د	D P P		27. Manner of Death  Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe ho	w injury occurred	
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Division of	si or Attandir saftar death. ! Director: Af d in by the fur	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str )	eet, factory, office		City or Town	reet and Number or F , State)	fural Houle Number,
_	pitai urs a erel [		29a. Certifier 1 Certifying Phys	iniana To the best of a live	ulandan dan d		data and along	and due to the co		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical		sician: To the best of my know har: On the basis of examinati and manner stated.						
	o the	Me	29b. Signature and title of certifier	7/		29c. Licenso			d. Date signed (Mor	
	~ s ⊢ ō		( )Z	and .	2	10.	41 71		1 Sent	2006
•	12		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	,000	2-		\$1701
	10		079	46.56 GM.	2	501 6	Un	150	F ed 7	2006 8170/ ~119b
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	ر فو				
	Regist	rar	SEP 0 8 200	Bolin D	The same	Sele				

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1 - State Registrar 28556 2. Date of Death September 2, 2006 12:30PM M Thomas Mills Gibbons 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick 7109 Poole Jones Road Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan. 31, Year) 9. Birthplace (State or Foreign Jan. 31, Year) 952 Washington, DC 5. Social Security Number 577-70-8292 7. Age (In yrs. last birthday) 54 Yrs. XXM 2□F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick 1 Tes XX No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7109 Poole Jones Road 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Sollege (1-4or 5+) Elementary/Secondary (0-12) Operations Manager Radio Stations 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude Mills James L. Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon M. Gibbons, wife 7109 Poole Jones Rd., Frederick, MD 21702 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resthaven Memorial Gardens Sept. 8, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licen Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF aRCINOMA THE SEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

physicien and the burial-transit

ettending for use as

certificate

Director: After this certific in by the funeral director,

To the Hospital or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages Depertment of H Important: if its eny injury or of pnce.

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

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Pages 1 end 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygiene. "Returel", or liteme 23a or 28e-f ehow and; if item 27 ie marked other then "naturel", or liteme 23a or 28e-f ehow ury or other freumatic event, ite Madicia Examina must be notified at

Baltimore, Maryland 21215-0036

Examine Completed by Physician/Medical Be မ Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERIOSCIERUTIC CARDIO-JASCULAR Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 🗌 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D10587 2006 1.1.~

within 24 hours a To the Funeral I comuletely filled filled

Medical

Registrar

M.D SHITH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HOSPICE OF FAEDERICK COUNTY MEDER DIRECTOR, STE TRAIL AUS.

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Reg. No.2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day ISABELLA GANLEY **Physician** September 4, 2006 5:12 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll County 225 Roth Averue Taneytown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🖫 F 92 050-10-4946 2, 1913 Scotland Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State ral', or iteme 23a or 28e-f show Examiner must be notified at X Yes 2 No Carroll County Maryland Taneytown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Roth Avenue 21787 United States filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baitimore, Maryland 21215-0036 "natural", or Specify: White 1 Yes 2X No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental sut: If Item 27 is marked o John Campbell Macdonald Jessie Black ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Jenkins / daughter 225 Roth Avenue Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 9 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3X Removal from State permit. Page Department of Important: If any injury or once. Daytona Beach, Florida Davtona Memorial Park 2006 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Skiles Funeral Home Alan ( 136 East Baltimore Street Taneytown, Md. 21787 un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic chesionAscular Immediate Cause (Final **Physician** 24 ens disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last signed by the attending physicien and Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 certificate has been signi rector, page 2 should be sevile demertia. Attahemen's Type 1 Yes 2 No 3 Probably 4 Unknown Be Completed dependent diabeto mellitu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To this ( 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Hospitel or Attending 5 Pending 1 Natural 1 Tes 2 No death. investigation after death. Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 24 hours a 1💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To tha the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Lill certifier 2 D31660 09/05/2006 1 CMC) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONER AURICE WE STM IN STER MARYLAND THOMAS GALVIN TO MA 291 pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2006

			1 - State Registrar	State of Maryla		ertificate of L		Re	19. No.2006	28558
	Physici /Medic		1. Decedent's Name (First, Middle, La E11a	Belle Green				2. Date of Death September	1, Day 2006 Year	3. Time of Death 12:05 AM <sub>M</sub>
A STATE OF THE PARTY OF THE PAR	Examin		4a. Facility Name (If not institution, give College View (			4b. City, Town, or Freder:			4c. County of Dea Frederi	
	Funeral Director		5. Social Security Number 6. S 218-03-2303	ex	. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 3	Уеа 1918 Ма	thplace (State or Foreign ountry) ryland
	yland		Usual Residence of Decedent  10a. State 10b. County		ity, Town or L					10d. tnside City Limits
	the Ma	ector	Maryland Frederic	CK F1	ederio	10f. Zip Code		11	ng. Citizen of What C	1 Yes 2 No
	eth with	Funeral Director	404 Delaware Ro			21701			U.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23e or 28e-f show each injury or other traumatic event, the Medical Examinant be redifficial approx.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in the Armed Forces?  1 ☐ Yes ② No If Yes, Give Year or Dates:	J.S. 13	. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 🏠 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
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any	and N	1	19a. Informant's Name/Relationship (	** *	19b. Mai	ling Address (Street a	nd Number or Rui	al Route Number,	City or Town, State,	Zip Code)
e, N	1 and Health em 27 ther tr		Lance Glisaon, no		Place of Disc	Timmons ]		-	ge, MD 217	
Baltimore, Maryland	it. Pages intment of rtent: If It njury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Pr	ospect (	ematory or other place Cemetery	Sept.	5, 2006 N	Mt. Airy,	
Ba	Depermination of the contract		21. Signature of Funeral Service Lines	10025 MOO25	55	<sup>22. Name and Addres</sup> Keeney an 106 East	d Basford Church S	d PA Fund t., Frede	eral Home erick, MD	21701
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart faiture. List only tmmediate Cause (Final disease or condition resulting in death)	one cause on each tine.  a. Demen	tia					Approximate Interval Between Onset and Death
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68760,	ficate be executed physicien and s the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a conse	quence of):					
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P.O. Box	The law requires that the death certifule has been signed by the attending tage? should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
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ō	Phys r this oral di	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time	ent 3 DOA	47 Nursing Ho	ome 5 Reside	nce 6 Other (Spe	ecify)
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Divis	<u>2</u> # €	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, s	treet, factory, office		28f. Location (Str. City or Town	eet and Number or R , State)	ural Route Number,
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)	To th To th comp	ž	29b. Signature that title of certifier	- MB		29c. License	number 60417		od. Date signed (Moni September	
	12		30. Name and address of person who Hemen Shah m	completed cause of death (Ite		o, Print)		Frederi	ac Mb	21702
+	Sta		31. Date filed (Month, Day, Year)	32. Sgistrar's Sign	ature	1 10				
	Registr	ar	SEP 0 8 2	JUD James.	15. A	parke				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23 2006 2:35PM August Callender Lillian /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George Clinton Bradford Oaks Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 120 42 5204 2 1953 New York June Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Camp Springs Prince George 10g. Citizen of What Country? 10e. Street and Number Funeral 20762 Court 5161 B Walmsley 14. Race - American Indian, 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black Saltimore, Maryland 21215-0020 2 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 12th grade Home Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Salvarria Mary Callender Stephen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5161 B Andrew AFB, Camp Springs, Md Tarri Long, daugther 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) Metropolitan Crematory 8/25/06 Alexandria Va. 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signature of Funeral Service Licensee m 0#-1161 621 Florida Avenue, NW, Washington, DC 20001 and the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner the attending physician and hed for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Anknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 🗆 Yes 1 ☐ Yes 2 ☐ No ai or Attending Physician: T s efter death. ii Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hursing Home 5 - Residence 6 - Other (Specify) 1☐ Yes 2☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death 28b Time of 28c. Injury at Work? 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

2

State Registrar 31. Date filed (Month, Day, Year) AUG 2 5 2006

29b. Signature and title of certifier

30 Name and address of person

1) 6/ Wing No Kd

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2006

1 - Stete Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 21/06 **Physician** Ellsworth F. Gibson Sr 2310p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Park If Under 2 Montgomery Takoma 8. Date of Birth 1 (Month, Day, Zear) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 XM 2 F Washington, DC Director 577-40-9680 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland anent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "natural", or Items 23s or 28s-f show ury or other treumatic event, The Medical Examplar Trust the notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 728 9th Street SE 20003 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes, Give 5 \_ 23 Year or Dates \_ 17 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Musician 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Furman E. Gibson Katherine Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Milfan Drive Capitol Heights, Md 20743 Ellsworth Gibson Jr-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Quantico National 08/30/06 Quantico, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaciliSnead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlake Pl Ste B Mitchellville, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Coronory Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Mellitus Dichetes 1 Yes 2 No 3 Probably 4 Unknown pentensive 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy rmed? 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending after death. 1 Tes 2 No 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funerel E Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2326 08177106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 carrel has Torkoma Park, Mid. SHT FOOT JAME 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 2006 24 AUG Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 21, 2006 **Physician** Geraldine 7:00 p. M Helen Geissler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1943 Marconi Circle Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 74 021-26-9078 May 31, 1932 Director Massachusetts Usual Residence of Decedenl the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Mudical Examinar must be mudified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1943 Marconi Circle 21401 United States Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Itam 27 is marked other them. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes 2√2 No Specify: Specify: White ģ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chester Peter Pitts Josephine O'Callaghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Geissler (husband) 1943 Marconi Circle Annapolis, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate August 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 2006 21. Signature of Fune al 3 rvice Licensee 22. Name and Address of Facility Advent Funeral & Cremetion Service M00982 42 Hudson St., Suite 110, Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Utritiona **Physician** 2 months /Medical Examiner Chronic Disorder 40 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed arkinson Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ ŧ 2 ER/Outpatient 3 DOA this 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident I Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, larm, street, factory, office building, etc. (Specify) after 4 - Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 0040904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARDA LN., ANNAPOL 1209A 0 RIVERA -KING, MD. NANCY D 31. Date liled (Month, Day, Year) 32. Segistrar's Signatur State 2006 Registrar

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J.C.	es 1 a of He of He fiterr r oth		20a. Method of Disp		3 Demoval	from State	20b. Pl	ace of Disp emetery, cre	osition (Nai matory or c	me of other plac	:e)		Date	20c. Loc	ation - City or T	own, State	
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Baltimore, Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any niury or other treumatic event, the Medical Exeminational Examinational Problems and Once.		21. Signature of Fu	neral Service I	icensee								st Haven				
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State of Mar	yland / Departmen	it of Health and	Mental H	lygiene 4	U	U

28563 For Stata Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 10:359M ALLEN 20,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Haspital Hoesda Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV 16, 19 Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 ☐ F 2258-07-0663 86 Yrs. Director North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai, or itsms 23a or 28a-f show Examiner must be notified at 1emple HII 1 ☐ Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? KICKEY AVE U.S. 19 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced "natursi" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1L,3. (sovernment Elementary/Secondary (0-12) Coltege (1-4or 5+) and Mental Hygiene. Labore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HOUVIN lance 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar Important: if itsm 27 is sny injury or other trauguce. Wife Mary Harvin 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Taylor 0 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23930 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 16 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy Wedgewinal 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient Medical Certification: To 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: 3 🗌 Suicide 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVSUANZ www 62. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 4 2006 State Registrar

1035AN

8/20/2006

HARNIN ALLEN

Harvey, Mary. L

32.0	e e	State Registrar  1. Decedent's Nam	o (Firet Middle 1			•	tificate of	Health and Death	2. Date of De	Reg. No.2	006	2856
, sicia		Mar		Loretta			Harvey		Month August	Day	Year	7.20
1edic amin	_		-	rive street and number	er)			or Location of Dea		-	unty of Death	7:20pm
		Civista	Medica1	Center			LaP1at	a		Char	cles	
al or		5. Social Security N 294–12–7	lumber 6.		Age (In yrs. la 82	ast birthday) Yrs.	If Under 1 Year Months Days			nth ay, Year) • 1924	9. Birth Cou Cal	place (State or Fore ntry) ifornia
	-	Usual Residence o	f Decedent 10b. County		10c. City	, Town or La	cation					10d. Inside City Lin
	ō	Maryland	Prince Ge	eorge's		er Marl						1 ☐ Yes 2 🙀
	Funeral Director	10e. Street and Nu			-FF		10f. Zip Code 20772	)		10g. Citizer USA	of What Cou	ntry?
	era	11. Marital Status	-8-3-3-	12. Was Decede	nt Ever in U.S	S. 13.	Was Decedent of	Hispanic Origin? (	Specify Yes or No		Race - Ameri	
	þ	1 Never Marr	ied 2 Marned	Armed Force  1 ☐ Yes 2 1  If Yes, Give  Year or Date	Ž No		f Yes, specify Cul 1 ☐ Yes 2, No	Specify:	rto Rican, etc.)	Sp	Black, White, ecity:	white
	ted	/Sne	15. Decedent's cify only highest of	Education		16a. Dece	dent's Usual Occu	pation	orkina	16b. Kind	of Business/In	ndustry
	Completed	Elementary/Seco		College (1-4c	or 5+)			during most of wo	nang	Tn	Home	
		17. Father's Name	(First Middle I a	4		1101	emaker	18 Mother's Na	me (First, Middle			
	o Be	Owen	Salisbury					Cather			marrie,	
	ှ	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Number or R	Pural Route Numb	per, City or To	wn, State, Zij	c Code)
		Gerald Ha	rvev / Son	1		1531 F	lawthorne ]	errace Ber	kėley, Cal	ifornia	94708	3
		20a. Method of Dis	position		co	ace of Dispo	sition (Name of natory or other pla		Date		ion - City or T	own, State
			✓5 ☐ Other (Spec	☐Removal from Sta cify)		ington	Nat. Cemet	ery 09/1	4/2006	Arlino	ton. Vir	ginia
once.		21. Signature Fi	uneral Service Lic	las d			2. Name and Addr 6160 Oxon	ess of Facility Hill Road	arge P. Ka			
		23a. Part1. Enter t shock, or hea	the disease, or co art failure. List on	emplications that causely one cause on each		. Do not ent	er the mode of dy					Approximate Interval Betwee
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il r		resulting in death)	1	Due to (or	as a consequ	enge of):	+ 4	PriVR				
	-	Sequentially list co	onditions,	b. Due to (or	as a consequ	ence of):	to T	JA VE				
-	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	erlying	b	elyc	lout	TON					
-	Exa	that initiated event resulting in death)	Last	Due to (or	as a consequ	ence of):						
	cal			d								
	Physician/Medic	IF FEMALE:										
1	lan/	23b. Was deceder in the past 12			2 Fetal	death 3[	Ectopic pregnani	су		23d	. Date of deliv Month	ery Day Year
	yslc	1 ☐ Yes & 9 ☐ Unknown	No No	4⊟Pregnant 9□ Unknowr	t at time of de	ath 5	Other (specify)					,
		Part II. Other signi	ficant conditions	contributing to death	h but not resu	Iting in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco use	couribute to t	he cause of death
	d by	Vas	culiti	5 , ,					1 🗆	Yes 2	o 3 Pro	bably 4 Unki
	lete	Chro	nze of	Struct	ve 1	bull	woner	4 1785	Ce Kara Was		4b. Were auto	opsy findings ava
	5-da	100-	queli p	atty,	1001	prec	121/	F	auto perfe	ormed?	prior to co death? 1  Yes	mpletion of cause
	D.		1 / 1	1//		, 0,	, , , ,	26. Place of De	eath (Check only		1 105	2U NO
	3e Completed	25. Was case refe	reg to medical		//	ER/Outpatier	nt 3□ DOA O	ther: 4 Nursing	Home 5□Res	idence 6	Other (Speci	fy)
	o Be	25. Was case rete examiner? 1 Yes 2	/	Hospital: 1 Inpa	atient 2 🗆 E			irv at	28d. Describe	how injury or	ccurred	
	To Be	examiner?	No th	Hospital: 1 Inpa		28b. Time o Injury	W					
	To Be	examiner? 1 Yes 2 1  27. Manner of Dea 1 Natural 2 Accident	No th 5 Pending investigat	28a. Date of li (Month, li	njury Day Year)	Injury	M 1	Yes 2 □ No		10.		
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			For State Registrer	State of Maryland		artment of H			giene Reg. No.2006	28565
, e	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     Betty B. Hedges     Hedges     Ha. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	2. Date of Dea Month Aug •	Day Year 24, 2006  4c. County of Dea	3. Time of Death 5:30 A <sup>M</sup>
	Funeral Director		212-24-3037	M 2XF 7. Age (In yrs. I	last birthday) Yrs.	Middle  If Under 1 Year  Months Days	etown If Under 24 Hrs Hours Min	8. Date of Birt (Month, Date of July 5	Frede 9. Bir	erick thplace (State or Foreign MD
	with the Maryland a or 28a-f ahow be notified at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Freder		y, Town or Lo	Middlet	own			10d. Inside City Limits 1 □XYes 2 □ No
	72 hours after death with the Maryland natural', or Itame 23a or 28e-f ahow Jical Ezandier must be notified at	Funeral Director	10e. Street and Number 4 Locust Blvd.  11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13.	10f. Zip Code  Vas Decedent of Hi f Yes, specify Cuba	21769		10g. Citizen of What Co USA 14. Race - Ame Black, Whit	A encan Indian,
21215-0036	d within 72 hours after death wiene.	by	1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	16a Deced	l Yes 2 No	Specify:			White
	ill Hygiene. other than "	3e Completed	Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	erator	18. Mother's Na	ame (First, Middle,	telephor	ne co.
Maryland	12 should h and Mer 7 le marke traumatic	To Be	Eli Clifford Be  19a. Informant's Name/Relationship (Tyx.  John K. Hedges	oe, Print)		-	and Number or F		ma or, City or Town, State, . Iiddletowr	
Baltimore,	permit. Pages 1 and Department of Healt Important: If itam 2: any injury or other to		20a. Method of Disposition  XIXBurlai 2 Cremation 3 Re 4 Donation 5 Other (Special)  21. Significance Funeral Service Licence	Lu	ithera	sition (Name of natory or other place an Cemet	ery 8/		20c. Location - City or Middletov	vn, MD
	Y T		23a Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death e cause on each line.	h. Do not ent	SI E. Ma er the mode of dying	g, such as cardia	, Middi	neral Hon etown, MI	Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner but side purjar, transit sthe purjar, transit states and transit states are states a	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of): uence of):	la Aceta	dest			Pzhruks
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
<u> </u>	requires that been signed should be de	þ	Part II. Other significant conditions con Hype-choleskrole	•	ulting in the u	nderlying cause give	en in Part I.	101		robably 4 2 Inknown
ital Rec		Be Completed	25. Was case referred to medical				26. Place of De	24a. Was autop perfo 1 Yes	prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
Division of Vital Records,	ing Phy After this uneral d	은	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1  Inpatient 2    28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injun Work	4 Nursing  / at Yes 2 No</td <td></td> <td>dence 6 Other (Spenow injury occurred</td> <td>city)</td>		dence 6 Other (Spenow injury occurred	city)
DIX	pital or Attend burs after death aral Director: , filled in by the f	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify sician: To the best of my known	y)		an data and place	City or Tou		
	To the Hoepital o within 24 hours aft To tha Funaral Di completely filled in	Medical	(Check only one)  2 Medical Examir  29b. Signature and title of certifier	ner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my of	pinion, death occ	curred at the time,	date and place, and dui	e to the cause(s)
1	7		30. Name an address of person who co	mpleted cause of death (Item	n 23a) (Tvoe		3)80		8/25/04	2
150	Sta	te	Keyla & Hohlma &	30x 20 300 S	Chine	1 st m	Adle for	m mi	21769	
	Registi		31. Date filed (Month, Day, Year) AUG 2 8 2	006 Men	K	Care.				

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			1- State of Maryland / Registrar	Department Certification	nt of He te of D	ealth and M Death	ental Hyg	giene 20	06	28566
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physici		Belle Bernice Harmon				Month August	Day 23. 20	Year 006	5:15 a M
}	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City	, Town, or	Location of Death			y of Death	
	E Aditiii		Collingswood Nursing & Rehab.	R	ockvi	11e		М	ontgo	mery
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last b.		r 1 Year	If Under 24 Hrs.	8. Date of Birt	h Vanal	9. Birthr	place (State or Foreign
	Director		169-01-8519 1□M 2XF 89	Yrs. Months	Days	Hours Min.	Sept. 2	4, 1916	Penn	place (State or Foreign ntry) sylvania
	P .		Usual Residence of Decedent							
	how	L	10a. State 10b. County 10c. City, Tow	wn or Location					1	Od. Inside City Limits
	e Ma	Director	Maryland Montgomery Roc	ckville						1 ☐ Yes ŽÃNo
	라 5g 8	lre-	10e. Street and Number	10f. Zi	p Code			10g. Citizen of	What Cour	ntry?
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	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow valical Estaturat from the nything at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of His	spanic Origin? (Spe , Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	
٥	or its		1 Never Married 2 Married 1 Yes 2 MNo If Yes, Give	1 ☐ Yes		Specify:	mouri, oto.,			
215-0036	ours Fair,	d by	3X Widowed 4 □ Divorced Year or Dates:	12.103	2 3 140	opeony.		эресп.	White	
ភ	72 h natu	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	a. Decedent's Usu (Give kind of w	ork done di	uring most of worki	ng	16b. Kind of E	lusiness/In	dustry
7	within 72 ene. than "nat	dr.	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT	,				<b></b>	
7	ygier yertt	Ö	1	Ca	se Wo					Organizatio
	a be fill hall H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Suma	πе)	
<u>X</u>	Men Arke	မ	Thomas McConkey			Susan M				
Maryland	permit. Pages 1 end 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than Important: Quiber freumatic event, the Monce.					ourt, Ro				Code)
gaitimore,	2 ± ± 1		comets	of Disposition (Na		Augus	ate 23	20c. Location	- City or To	own, State
Ĕ	Page nt: #		I Burial 2 Deremation 3 Hemoval from State	olitan Cre				Alexandr	ia. Vi	rginia
Ħ	mit. Sartm Sorta inju		21. Signature of Funeral Service Licens			lins"Funer				
ñ	Depar Depar Impor eny ir		John E. ( Yarken			Blvd, W,			20901	
۲			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or flear fallure. List only one cause on each line.							Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence	of):			<del> </del>			
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ň	uires that the death certific signed by the attending f d be detached for use as	Physician/Me	in the past 12 months?	th 3 Ectopic p 5 Other (s					onth	Day Year
j.	the d y the	ıysı	1 Yes 2 No 9 Unknown 9 Unknown							
7	requires that een signed b nould be deta		Part II. Other significant conditions contributing to death but not resulting	in the underlying	cause give	n in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
as,	sign d be	d by					1 🗆 Y	es 2 No	3 Prob	ably 4 Unknown
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ě	e la hes je 2	ם					24a. Was autop	SV	prior to cor death?	psy findings available mpletion of cause of
	t: The licete he						perfor 1 ☐ Yes	2 No	1 🗆 Yes	2 No
=	Physicien: Th this certificate rat director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Other	26. Place of Death	2000	7.0		
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	si or Attending Physicien: after death. I Director: After this certific d in by the funeral director,	Certification:	1 X Natural 5 ☐ Pending (Month, Day Year)		28c. Injury Work		28d. Describe h	ow injury occu	red	
DIVISION	feath feath for:	cat	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury - At home to	М		es 2 No				
⋛	or Al	E	4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, factor	y, office		City or Tow		ber or Rura	I Route Number,
_	pital urs a arai (		(TV2)							
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	ge, death occurred ind/or investigation	at the time n, in my opi	e, date and place, a inion, death occurr	and due to the o ed at the time, o	ause(s) and m date and place,	anner as st and due to	tated. o the cause(s)
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier		c. License					
ı	S T N		(D)	29	D301			29d. Date signe August		
,	2/		Thorn M.J		5501	- L				
			30. Name and address of person who completed cause of death (Item 23a) Rita Ghosh, M.D. 14812 Physicia		О 11.1	61 D1-		WD 2005	0	
						OI, KOCK	viile,	MD 2002		
	Sta		AUG 2 4 2006 32-Registrar's Signature	Coule						
1	Registr	al	HUU A T LOO							

State of Maryland / Department of Health and Mental Hygiene 2006 28567 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 9:30 p 20 2006 Hardesty August Theodore Robert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Heritage Harbour Health & Rehab. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 80 Yrs. 215-30-2617 Sept 29 1925 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Davidsonville Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 1287 Rossback Road 21035 USA death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, ltems 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 6 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Foreman Construction ... Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: If Item 27 is marked other t jury or other traumatic event, to other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lambert L. Hardesty Agnes Steiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1287 Rossback Road, Davidsonville, MD 21035 Virginia P. Hardesty (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of important: If eny injury or once. 8-22-2006 Metro Crematory Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8 Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cayse given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation after death the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 9055 31. Date filed (Month, Day, Year)
AUG 2:3 2006 Registrar's Signature State Registrar

		•	For State Registrar	State of Maryland / D		nent of He			giene Reg. N20	06	285	68
.#.	Physicia	an	Decedent's Name (First, Middle, Last)	- Dansey Johnson				2. Date of De	Day 28	Year 2006	3. Time of	Death P M
	/Medic		4a. Facility Name (If not institution, give str	n Dorsey Johnson		City, Town, or	Location of D	August		2000 ity of Death	1550	P ""
交	L Admin	CI .	Laurelwood Care Ce	nter		E1kton			Cec	il.		
<b>3</b> ₩	Funeral Director		214-18-2845	7. Age (In yrs. last birth		Inder 1 Year onths Days	If Under 24 h	Hrs. 8. Date of Birt (Month, Da NOV 20	y, Year)	Cour	place (State on htry) 1 and	r Foreign
	land ow		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town	or Location	n				1	0d. Inside Cit	ly Limits
	Mary	ctor	Maryland Cecil	E1kto	on						1 XYes	2 🗌 No
	or 28	Directo	10e. Street and Number		10	of. Zip Code			10g. Citizen o		•	
	eath v	Funeral	514 Bow Street  11. Marital Status	. Was Decedent Ever in U.S.	13 Was f	21921	nanic Origin?	(Specify Yes or No		ed St		
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or items 23s or 28e-f show aumatic event, it is Medical Exam are must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? World  1 Types 2 No World  If Yes, Give Year or Dates: War II	If Yes	es 2 No	Specify:	uerto Rican, etc.)		lack, White,		
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give kind	Usual Occupa of work done do	uring most of	working	16b. Kind of			
12	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired) ian Emp			United Govern		es	
<u>5</u>	illed Hygid other	a)	17. Father's Name (First, Middle, Last)		JI V II.	-		Name (First, Middle,				
ylar	Menta Menta arked atic ev	To B	Clayton Johnson					a H. Purdy				
Mar	d 2 shi th and 7 is m traum		19a. Informant's Name/Relationship (Type Charles C. Johnson					Rural Route Numbe			Code)	
<u>.</u>	f Heal f Heal tem 2		20a. Method of Disposition	20b. Place of				ton, Maryî otember 1,	20c. Location		own, State	
Ē	Page nent o nnt: if ury or		1 X Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Bethe1			200		Chesa	peake	City,	MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evonce.		21. Signature of Funeral Service Licensee		Hick 103	ne and Address S Home W. Stoc	for Fuckton S	nerals, P Street, El	A. kton,	Maryla	and 219	921
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			For State Registrar	State of	Maryland		artment of rtificate o					2006	28569
	Physici		Decedent's Name (First, Middle, La     CLADEST	JEAN	JONES					2. Date of De Month August	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City, Town			August	4c.	County of Death	8:00am M
	Funeral		5. Social Security Number 6.		Age (In yrs. las	t birthday)	If Under 1 Ye  Months Da		der 24 Hrs.	8. Date of Bir (Month, Da	th	nce Geoi	place (State or Foreign
	Director		579-44-3572 Usual Residence of Decedent	1□M 2√2F	73	Yrs.	Months Da	ys Hou	is Mill.	Sept.	14,1	932 Dany	ville, Va.
	yland how		10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City Limits
	8a-1 s	Funeral Director	D.C.		Wash	ingto							1√2 Yes 2 □ No
	with the sor 2	Dire	10e. Street and Number 1622 Varnum Pl.,	NE			10f. Zip Cod 2001					zen of What Cou	ntry?
	death ma 23	nera	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.			Origin? (Sp	ecify Yes or No Rican, etc.)		S.A. 14. Race - Americ	can Indian,
920	urs atter o al', or Iter	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 🗋 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	<b>₹</b> ] No	1	fYes, specify C 1 ☐ Yes 2 🔯 i			Rican, etc.)		Black, White, Specify: Black	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Medical Exertified in conference of the resilied at once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during r	nost of work	ing	16b. Kir	nd of Business/In	dustry
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ano	id be fi ental F kad ot c ever	To Be	17. Father's Name (First, Middle, Las.  John Jackson	0					other's Nam ola Ma	e (First, Middle, xton	Maiden .	Sumame)	
ary	and Moules mark	F	19a. Informant's Name/Relationship					eet and Nu	mber or Rur	al Route Numbe		Town, State, Zip	Code)
	l and 2 lealth im 27 in		Elma McNeill/Sis-	-in-Law			2nd Pla sition (Name of			DC 2001			
nor	ages and of H		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci		ate cem	etery, cren	natory or other	place)	1	Date		cation - City or To	
Baltimore,	permit. F Departme Importan any injur		21. Signature of Funeral Se e Lice		/ Harm	22	1em. Pk	dress of Fa	00	hnson &	Jenl	over, Mo kins Inc	
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	To the Hospital or Attending within 24 hours atter death.  To the Funeral Director: Atter completely filled in by the tuner	Medical (	29a. Certifier 1 Certifying Pl (Chack only one) 2 Medical Exam	nysician: To the be niner: On the basis and manner	s of examination	dge, death and/or inv	occurred at the restigation, in m	time, date y opinion, d	and place, death occurr	and due to the deed at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	11	->	29c. Lice	ense numb	ər			signed (Month,	
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_	9		30. Name and address of person who Georges C. Awa	h, 106	Irving S	St. S	uite 41	0, Wa	sh D.O	C. 2041	4		
	Sta		31. Date filed (Month, Day, Year)	Z. Regi	istrar's Signature	La	R,						
	Registr	ar	AUG 2 5 200	b Deter	U A	14							

Jones,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	Sta	ate of M	laryland	-	artmen				ental H	giene	006		285	70
	Physici	an	Decedent's Name (First, Middle	, Last)								2. Date of D Month	Day		ar	3. Time of E	
	/Medic	al	Robert  4a. Facility Name (If not institution	E.			Jones	45 65	T	Location of		August		2006 County of E	No or th	1450	РМ
	Examin	er	Anne Arundel M					**	apo1		OI Death			Anne A		de1	
	Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. Ia	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of B					Foreign
	Director		450-46-7183	1 <b>]K</b> ] M 2	F	74	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D April	7,193	2 A	ust	ice (State or y) In, Te	xas
	and		Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or Lo	cation							10	d. Inside City	/ Limits
	Maryl -f sho lied a	ğ	MD Princ	e Geor	000		Temp1	e Hil	1s							1 🔀 Yes	2 🗌 No
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	23a c	a D	3518 Everest D	rive				20	748				U	SA			
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 la marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 12	as Decedent med Forces ∑Yes 2 ☐ Yes, Give ear or Dates:	?	1	Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		cify Yes or N Rican, etc.)		14. Race - A Black, V Specify:	Vhite, e	tc.	
200	72 hor	ted	15. Deceden (Specify only highes				16a. Dece	dent's Usua kind of wo	I Occupa	ation	et of working	10	16b. Ki	nd of Busine	ess/Indu	ıstry	
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Maryland	should be fand Mental Merical Mental Mental Merical Mental Mental Merical Mental Merical Meric	То Ве	Frank N. Jones	2001)						Rut	_	L.		ander			
Mar	2 sho		19a. Informant's Name/Relations				1	_				Route Num	-			Code)	
	1 and Health em 27 ther tr		Christine M. J	ones/	wire	20b. Pl						e Hill		D 207 cation - City		m. State	
ğ	Pages nent of I int: if it		1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		al from State		ace of Dispo metery, crei				18/25	/2006					and
Baltimore,	permit. P Departme Importan any injur		21. Signature of Funeral Service		201	1	22	. Name an	d Addres	s of Facilit	ty J.B	. Jenk Landov	ins l	Funera			ind
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	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Due to (or a	_5	Joana ence of):	Chur	id	Hen	norr	hage			1	Onset and Di	eath
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Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospita	al· •				Othe			(Check only					
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)	To the within To the comp	Me	29b. Signature and title of certified	read	Bech	nD			DY	number 1605				e signed (M		ay, Year)	
			30. Name and address of person	who complet	ed cause of	death (Item 2001	23a) (Type,	Print)	Poul	way	, a	hnapo	los,	tuo			
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 3 20	006	32. Regis	trar's Signat	ure	ne of				inapo			-		
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		1	For State Registrar	State	of Maryl				lealth a Death		lental Hygi	iene	2006	28571
		_	Decedent's Name (First, Middle, Last)  2 Date of Death Month							h Day	Year	3. Time of Death		
Phys /Me	icia: dica	_	ROBERT THOMAS JORDAN							AUGUST 20, 2006 10			10:20 PM	
Exar			4a. Facility Name (If not institution	, give street and	number)		4b. City	, Town, or	Location of	of Death		4c. (	County of Dear	th
			37011 INTERNAT				lf I lode	SII or 1 Year	LVER SI		O Data of Dist		MONTGOME	
Funer		1	5. Social Security Number	6. Sex 1 X M 2 □ I	F	yrs. last birthday, Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day,			hplace (State or Foreign buntry)
Direct	or		023-03-6026 86 YIS JULY 04, 1						1920	MA	AINE			
yland			10a. State 10b. County		100	. City, Town or L	ocation							10d. Inside City Limits
e Mar			MARYLAND MONTGO	SILVER SPRING								1 ☐ Yes 2X No		
ith th		Director	10e. Street and Number 10f. Zip Code 10g						0g. Citiz	en of What Co	ountry?			
eth w	1	20	37011 INTERNATIONAL DRIVE					20906				1	U.S.A.	
er de		Laneral	11. Marital Status	Amed	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No			Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,				'	Black, Whit	
urs aff		à	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes,	If Yes, Give Year or Dates: WWII			1 ☐ Yes 2 ☑ No Specify:					Specify:	WHITE
2 hou		eg	15. Decedent		ducation 16a Dece			ident's Usual Occupation				16b. Kind of Business/Industry		
thin 7		Completed	(Specify only highes Elementary/Secondary (0-12)	T	College (1-4or 5+)			e kind of work done during most of working DO NOT use retired)						
III ( Z. I. Z. I. 2)-0030 be filed within 72 hours after deeth with the Maryland tal Hygiene. To on other then "natural", or terms 23a or 28a-f show event, the Medical Evantian transite a confine an		֡֝֓֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֓֓֡֓֓֡֓	4 MANAGEMENT ANALYST						/5: Asidd: 1	U.S. GOVERNMENT				
d be fill what Hy ked ofth		ď	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maid											
should nd Men		<u> </u>	JOSEPH EDWARD  19a. Informant's Name/Relations			19h Mail	ing Addres	es (Street			HERESA BROWN BOOK			Zin Code)
Man d2s lth an 27 is 1		- (	THERESA J. FINCH											
initiorie), Mar ylario Z IZ IZ-0000 air. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan arment of Health and Mental Hygiene. ortant: if item 27 is marked other then "natural; or items 23a or 28a-f show notary or other traumatic event, the Medical Example and included in Auther and	L	THERESA J. FINCH - DAUGHTER  128 LANDING DRIVE, REHOBOTH BEACH, DELAWARE 19  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - Ci												
Pages nent of int: if it	1		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S						1	8/25	/2006 S	ILVE	R SPRING	MARYLAND
mit. Pages partment of portant: if it			4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 8/25/2006 SILVER SPRING, MARYLAND  21. Signature of Funeral Server Cemeter 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC											
Department of the control of the con	а		11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904											
Physicia	an		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.  Immediate Cause (Final disease or condition DEMENTIA							est,		Approximate Interval Between Onset and Death 11 YEARS		
/Medic Examin	_		resulting in death)  Due to (or as a consequence of):											
Examin			Sequentially list conditions,	D. —	b. CEREBRO VASCULAR ARTERIOSCLEROSIS									11 YEARS
bei ist			Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that infiltated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
ou, be executed icien and burial-transit		Examiner												
ate be executed by sicien and he burial-transit		Cal												
Certificat certificat Iding physe as the														
that the death certificated by the ettending phedeleched for use as the		Pnysician/M	IF FEMALE: 23b. Was decedent pregnant 1						,				23d. Date of delivery  Month Day Year	
e death the etter		200	in the past 12 months?  1								Month Day real			
that the	1									oacco u	cco use contribute to the cause of death?			
		<u></u>							es 2 □ No 3 □ Probably 4 তুUnknown					
		<u>e</u>							24a. Wasa	an 24b. Were autopsy findings available				
be as 6		Completed	autop perfor						sy prior to completion of cause of death?					
VICEL FIGURE TO MICHAEL TO CONTINUE DE CON		a)	25. Was case referred to medica	- 3					26. Place	e of Deat	1 ☐ Yes 2 h (Check only on		1 1 10:	2 140
W 73		0	examiner?  Hospital: 1   Inpatient 2   FR/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)							ocify)				
			27. Manner of Death 28a. Date of Injury 28b. Time 1 ⊠Natural 5 □ Pending (Month, Day Year) Injury				of 28c. Injury at Work? 28d.			28d. Describe ho	3d. Describe how injury occurred			
VISION Attending r death. ector: Afte		cati	2 Accident investigation M 1 Yes 2 No					Yes 2	No	206 Landing (Chart and Mumber of Charl Could Mumber				
or Att		Certification:						<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>						
pital			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
TO the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A		edicai	(Check only one)  Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due one)											
To the Forth		Ş.								9d. Date	Date signed (Month, Day, Year)			
			Leonge le Mustalle D12121						AUGUST 23, 2006					
5		-	30. Name and address of person											
			GEORGE SENGSTA						MARYLA	ND 20	906			
Rec	Stat istra		31. Date filed (Month, Day, Year) AUG 2	4 2006	32. Digistrar's	Signature	parte							

			Please I	State of Maryland	I / Department of	nk. Ensure A	II Copies Al	re Legible.	00570		
		•	For State Registrar	State of Marytano	Certificate	of Death	Reg.		28572		
	Physici	an	Decedent's Name (First, Middle, Last)	D	14 42		2. Date of Death Month	Day Year	3. Time of Death		
	/Medic Examin		MARY 4a. Facility Name (If not institution, give s		KECK 4b. City, Tov	n, or Location of Death		4c. County of Death			
			JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BACTIMOR								
e	Funeral Director		5. Social Security Number 6. Sex 194-42-6579	7. Age (In yrs. Ia	Months D	ear If Under 24 Hrs.  ays Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birth Cou	place (State or Foreign Intry)		
	land DW		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin								
e, Maryland 2121	e Mary	ctor	PA LANO	ASTER COLUMBIA					1 Tes 2 No		
	Min in	Director									
	r death	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White			
	ours after death with the Marylar rel', or Iteme 23a or 28a-f show Examinar must be notified at	Þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀	/	,	Specify: UJF	+iTE		
	72 hours 'naturel', dical Exe	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual O (Give kind of work d	ccupation one during most of worl atired)	sing 16	b. Kind of Business/l	ndustry		
	i within 72 ho jiene. r then "natur ine Medicel	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)	DISABL			NIA			
	ild be filed lental Hygid ked other ic event.	Be	17. Father's Name (First, Middle, Last)	2111111111		18. Mother's Nam	e (First, Middle, Mai	iden Sumame)			
	d 2 should th and Men ?7 le marke traumatic	၉	ANTHUR 71. DENLINGER VIOLE					T LAMPARTER ral Route Number, by or Town, State, Zi. Code)			
	and 2:		JANET L. SHER	MAN DAUGHT	or 13 MG	ALUSTE	est, H	ANOVEY 1	A 17331		
	or ot		20a. Method of Disposition  1 □ Burial 2 Scremation 3 □ R  4 □ Donation 5 □ Other (Specify)	, 20b. Pla	ace of Disposition (Name of metery, crematory or other	place)	2, 2006 L	c. Location - City or T	Own, State		
altin	P. Inje		21. Signature of Funery Service License	X Z	22. Name and A	ddress of Facility J	J. Hartens	stein Mort	uary,Inc.		
Ω.	Per		The Harles	enstein	24 Seco	ond St.,	New Free	dom, PA	17349		
	Physician /Medical Examiner		23a. Fig.1: Egist the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Inmediate Cause (Final								
			disease or condition resulting in death)	Due to (or as a consequence of):							
		e	Sequentially list conditions, if any, leading to immediate	BILATERAL PNEUMONIA  Due to (or as a consequence of).  SYSTEMIC LUPUS ERYTHEMATOSYS							
<b>V</b>	te be executed ysician and te burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SYSTEMIC							
760,		cal E	d	Due to (or as a conseque							
. 68	death certificate e attending phy od for use as the	Medic	IF FEMALE:		- William						
Вох	that the death certificate ed by the attending phys detached for use as the	by Physician/Medi	23b. Was decedent pregnant in the past 12 morths?	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea		23d. Date of deliv Month					
P.O.	at the o	Physi	1 Yes 2 No 9 Unknown	9□ Unknown							
	w requires that the sbeen signed by the should be detached	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba 1   Yes  24a. Was an						cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
scor	N C C	Completed									
a R	The ate h	Com					autopsy performed 1 Yes 2	d2 death?	ompletion of cause of 2 □ No		
Zit	Physician: Th this certificate ral director, pag	0	25. Was case referred to medical examiner?  1 2/9s 2 No  26. Place of Death   Check only one    Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Division of Vital Records,	ng Phy Mer this	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending			Injury at Work?	28d. Describe how		рөспу)		
	Attend death ctor: /	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	M Mne, farm, street, factory, of	28f. Location (Street and Number or Rural Route Number,					
Ď.	rs after		4   Homole	building, etc. (Specify)  City or Town, Sta							
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death occurred at the analysis in and/or investigation, in it	ne time, date and place, my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
. :	To th To th compl	Me	29b. Signature and title of certifier  29c. License number  RES - 000  08/31/  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SONNTHAN  MITH  4440  FAITHIN AVENUE  BALTIMANE  32 Teglistrar's Signature  SEP 3 8 2006								
				08/31/06							
	/		30. Name and address of person who con	mpleted cause of death (Item 2							
	15		SONATH A.  31. Date filed (Month, Day, Year)	BATH, 4	2940 FASTEN	1 AVERUE	BALTIMACE	5, MO 3	1224		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 11:25 AM August 22 Florence Frances Keith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 12924 Victoria Heights Drive Bowie 8. Date of Birth (Month, Day, Year) Apr. 5, 1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1 □ M 2X F Mass. 022-20-6506 79 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State in then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1. Yes 2 □ No Director Bowie Prince George's MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 20715 12924 Victoria Heights Drive Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itemeny Injury or other traumation. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Admin. Assistant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Cisek Michael Hojlo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Osterville, MA. 70 Bonnie Briar Dr. Paul Hojlo / brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Metropolitan Crematory 08/23/2006 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physicien detached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown this certificate has been signed by all director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No or Attending Physicien: : After this certifical funeral director, I 25. Was case referred to medical 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 【XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide To the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my online. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a d title of ce D29142 Aug. 23, 2006 s of person who completed cause of death (Item 23a) (Type, Print) Annapolis, MD. 21401

State Registrar

31. Date filed (Month, Day, Year) AUG 2 3 2006

Charles Boice, M.D.

2001 Medical Parkway 32. Registrar's Signature

*		1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryla	•		nt of Health and te of Death	2. Date of Dea	eg. N2006	3. Time of Death	
Physici /Medic Examir	cal	Arthur Louis  4a. Facility Name (If not institution, give s  24465 Budds Creek Ro  5. Social Security Number 6. Sex	ad	s. last birthday)		Town, or Location of Deat Clements r 1 Year   If Under 24 Hrs	h	30, 2006  4c. County of De. St. Mary	8:20 A M	
Funeral Director		5. Social Security Number 6. Sex 1216–14–5736 125	M 2□F 8		Months			1919 Mar	yland	
he Maryland 186-1 ehow	Director	Maryland St. Mary		Clements		0.4		log. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2XXNo	
with t	I Dir	10e. Street and Number 24465 Budds Creek Road	d			p Code 0624		USA	Southly?	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or iteme 23a or 28e-f ehow event, the Madital Examinal must be notified.	by Funeral		12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.		dent of Hispanic Origin? (S orify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh		
within 72 housens.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usu kind of wi DO NOT L	ial Occupation ork done during most of wo ise retired)	rking	16b. Kind of Business/Industry  Agriculture		
m - 0 5	To Be C	17. Father's Name (First, Middle, Last)  John Louis Knott				Catheri	me (First, Middle, ne Maria' (	Quade		
nd 2 sho alth and 27 ie m ir treum		19a. Informant's Name/Relationship (Type Cheryl Jean Knott / Gra				s (Street and Number or Ri s Creek Road, C				
permit. Pages 1 and 2 should be Depertment of Health and Menta Important: if Item 27 ie marked eny Injury or other treumatic ev QRGe.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b emoval from State	Place of Displicemetery, cre Joseph		, -	eptember 2006	20c. Location - City of Morganza, Ma		
permit. F Depertm Importation only Injure		21. Signature of Funeral Service License				nd Address of Facility Ley-Gardiner Fun x 270, Leonardu	the state of the s			
Physician pe executed and state of transit transit to use as the buriel-transit	Ilcal Examiner	23a. Part1. Enter the disease, a complication shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  5.3. Use Aliasty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	Due to (or as a consi	equence of):  CV equence of):	A Company	de of dying, such as cardia	c or respiratory ari	est.	Approximate interval Between Onset and Death	
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic p □ Other (s			23d. Date ol d Month	elivery Day Year	
w requires that i been signed by should be deta		Part II. Other significant conditions con	tributing to death but not r	esulting in the u	underlying	cause given in Part I.	1	bacco use contribute es 2 □ No 3 □ I	to the cause of death?  Probably 4 Junknow	
: The law re cate has bee page 2 sho	Completed						24a. Was a autop perfor 1 🗆 Yes	sy prior to		
certifi	Be	25. Was case referred to medical examiner?	lospital:			Other	ath (Check only or			
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	atlon; To	1 Yes 2 No  27. Manner of leat  1 Natural 5 Pending 2 Accident investigation	1 ☐ inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injury at Work? 1 Yes 2 No		ence 6 Other (Sp ow injury occurred	oecity)	
s after des	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, larm, si cify)	treet, facto	ry, office	281. Location (S City or Tow	treet and Number or in, State)	Rural Route Number,	
e Hospitei 24 hours e Funerei letely filled	Medical		sician: To the best of my k ner: On the basis of exami and manner stated.							
To the within To the comple	Me	29b. Signature and title of certified	/		29	c. License number		29d. Date signed (Mo	nth, Day, Year)	
00		· Wh	M Ton	1		014285		8-31	-a6.	
,		30. Name and address of person who co Dr. William D.				Lookout Road,	Leonardtow	n, Maryland 2	20650	
St. Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 1 2006	32. Registrar's Sig	nature	KA					

الا يوليا	1 - State Registrar		Cen	tificate of L	Death	F	Reg. No.			
	1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	ith Day	Year	3. Time of De	eath
Physician		lakring, Sr.				August			7:00	Αм
/Medical Examiner	4. Facility Name (If and institution			4b. City, Town, or	Location of Death		4c. County	of Death		
	938 Ships Bell	l Court		Anna	apolis		Aı	nne A	rundel	
neral	5. Social Security Number	6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h Yearl	9. Birthpl	ace (State or F	oreign
ector	220-16-7950	<b>X</b> XM 2□F 78	Yrs.	MOILIIS Days	Hours Will.	Oct. 20	,1927		land	
	Usual Residence of Decedent									
oner traumatic event, trempleted by Funeral Director	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10	0d. Inside City	
5	Maryland Anne	Arunde1	Ann	apolis					1 ☐ Yes 2	WW.
<u>ē</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?	
ie O	938 Ships Bell	Court		21401			United	State	es	
Funeral Directo	11, Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. W	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Rad	e - America		
교	1 ☐ Never Married 2 💢 Marr		47-	☐ Yes 2 X No	Specify:		Specify			
þ		Year or Dates: 194	49		эроспу.		Зресп	Whi	te	
Completed	15. Deceden	nt's Education est grade completed)	16a. Deced	ent's Usual Occupa	ition Juring most of wor	kina	16b. Kind of B	usiness/Ind	lustry	
ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired						
5	10		F	irefighte			US Nava		demy	
Be (	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	ne (First, Middle,	Maiden Suman	ne)		
To	George	Ireland Klakring			Bessie	Whitting	ton			
	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailin	g Address (Street a				State, Zip	Code)	
	Anita J. Klakr:	ing / Wife	938 Sh	ips Bell	Court,	Annapoli	s, MD 2	1401		
	20a. Method of Disposition	20b. P	Place of Dispos	sition (Name of natory or other place		Date	20c. Location -		wn, State	
	1 ☐ Burial 2 ☼ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Hemoval from State		Cremato	-	/06	Baltimo	re M	arvlanc	4
	21. Signature of Funeral Service			Name and Addres						
	Michie	A. Kitta	-	7 Duke of					-	
	23a Part1 Enter the disease, o	r complications that caused the deat	th. Do not ente	or the mode of dvin	. such as cardia	or respiratory ar	rest.	IIS M	Approximate	
	shock, otheart failure. List	t only one cause on each line.							Interval Betwee Onset and De	
	Immediate Cause (Final disease or condition resulting in death)	-a Metast	Atic	- CA	reINO	MA				
	resulting in death)	Due to (or as a conseq	quence of):	0	0 11					
l.	Sequentially list conditions,	b. CArcie	UOM!	A (15)	Indde	1				
iner	if any, leading to immediate	Due to (or as a conseq	tuence of):							
Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Nem.								
		Due to (or as a conseq	quence of):							
ca		d						_		
Medical	IF FEMALE:							-		
		23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy				ite of delive onth	ny Day Ye	25
Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d	death 5	Other (specify)		-		24111	Day 10	u.
2	9 ☐ Unknown									
든	Part II ather significant conditi	ions contributing to death but not res	sulting in the un	derlying cause givi	en in Part I.		obacco use con			
by Ph	1 / /	LE LYDSTAK	- CA	rcinam	A	1 🗆 ነ	res 2□No	3 Prob	abiy 4 □Un	known
5								Were autor	psy findings av mpletion of cau	allable
ğ						24a. Was	an 24b.		ispietion or cau	20 01
Š						autop	an 24b.	death?	2□ No	
Completed by	PVESUMPTIO				26 Place of De	autop perfo 1 Yes	2 No	death?	2 No	
Be Completed by	25. Was case referred to medica examiner?	Hospital:	TER/Outpetrop	Othi	200	autor perfo 1 ☐ Yes ath (Check only o	2 No	1 Yes	2 No	
To Be Completed by	25. Was case referred to medica examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	T 3L DOA	er: 4 🗆 Nursing H	autor perfo 1 ☐ Yes  ath (Check only of the control of the contro	2 No	1 □ Yes ner (Specify	2 No	
To Be Completed by	25. Was case referred to medica examiner?	Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)		28c. Injun Work	er: 4 🗆 Nursing H	autor perfo 1 ☐ Yes  ath (Check only of the control of the contro	2 ⊈Nio ne) dence 6 ⊟Oth	1 □ Yes ner (Specify	2 No	
To Be Completed by	25. Was case referred to medica examiner?	Hospital: 1 Inpatient 2 Inpati	28b. Time of Injury	28c. Injun Word M 1	9F: 4 ☐ Nursing H y at k?	autor perfo 1 Ves ath (Check only of lome 5 Nesic 28d. Describe I	2. <b>J</b> Wio nne) dence 6. ☐ Ott now injury occur	1 □ Yes ner (Specify	2 No ()	36.
To Be Completed by	25. Was case referred to medica examiner?	Hospital: 1	28b. Time of Injury	28c. Injun Word M 1	9F: 4 ☐ Nursing H y at k?	autor perfo 1 Ves ath (Check only of lome 5 Nesic 28d. Describe I	2 No Other	1 □ Yes ner (Specify	2 No ()	9r,
Certification: To Be Completed by	25. Was case referred to medical examiner?  1	Hospital: 1	28b. Time of Injury nome, farm, stre	28c. Injun Word M 1 1	<sup>ac:</sup> 4 □ Nursing H r at c? Yes 2 □ No	autop perfo 1 ☐ Yes  ath (Check only of lome 5 ☐ Aesic 28d. Describe I  28f. Location ( City or Tou	2 (Mo)  dence 6 (Oth  now injury occur  Street and Number  vn, State)	1 ☐ Yes  ner (Specify  red  ber or Rura	2 No	<i>∍</i> ۲,
Certification; To Be Completed by	25. Was case referred to medical examiner?  1	Hospital: 1 Inpatient 2 Inpati	28b. Time of Injury	28c. Injun Work M 1 1 3	90: 4 Nursing H	autoperforment of the control of the	2 (No one)  dence 6 (Ott one)  Street and Number, State)	ner (Specify	2 No	3r,
edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pendia invest  3  Suicide 6  Could  4  Homicide determ  29a. Certifier (Check only one)	Hospital: 1 Inpatient 2 Ingation 2 Ingation Inot be mined 28e. Place of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special Examiner: On the basis of examiner and manner stated.	28b. Time of Injury	28c. Injun World M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	4 Nursing H	autop perfo 1 Yes  ath (Check only of tome 5 Nesic 28d. Describe to 28f. Location (Scity or Tow to an due to the turned at the time,	2 (No one)  dence 6 (Otherwise)  Street and Number, State)	ner (Specify red	2 No  // No  I Route Number  ated. the cause(s)	3f,
Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pendia invest  2  Accident invest  3  Suicide 6  Could determ  29a. Certifier (Check only one)	Hospital: 1 Inpatient 2 Ingation 2 Ingation Inot be mined 28e. Place of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special Examiner: On the basis of examiner and manner stated.	28b. Time of Injury	28c. Injuny Work M 1 1 29et, factory, office	4 Nursing H  y at  (?  Yes 2 No  he, date and place be number	autoperforment of the control of the	2 (No lence)  dence 6 (Ott now injury occur  Street and Number, State)  cause(s) and made and place,	ner (Specify red	2 No  // No  I Route Number  ated. the cause(s)	97.
edicai Certification; To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pendia invest  3  Suicide 6  Could  4  Homicide determ  29a. Certifier (Check only one)	Hospital: 1 Inpatient 2 Ingation 2 Ingation Inot be mined 28e. Place of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special Examiner: On the basis of examiner and manner stated.	28b. Time of Injury	28c. Injuny Work M 1 1 29et, factory, office	4 Nursing H  y at  (?  Yes 2 No  he, date and place be number	autoperforment of the control of the	2 (No lence)  dence 6 (Ott now injury occur  Street and Number, State)  cause(s) and made and place,	ner (Specify red	2 No  // No  I Route Number  ated. the cause(s)	91,
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			1 _ State	State of Maryland /	Department of Certificate o				28576
			Registrar  1. Decedent's Name (First, Middle, Last)		ocrimoate o	Dodin	2. Date of Death	10.C U U U	3. Time of Death
П	Physicia			roria Linkin	S			Day Yeer 26, 200	6 2:45AM <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give s			n, or Location of Death		4c. County of Deat	
			SOUTHERN MARYLAN			INTON		RINCE, G	
	Funeral		5. Social Security Number 6. Sex	X-V-	irthday) If Under 1 Ye  Months Day		8. Date of Birth (Month, Day, Yea	9. Birtl	hplace (State or Foreign untry)
	Director		217-76-3967	92	11.0.		AUG.20,	1914 MA	RYLAND
	yland		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
	e Ma	ctor	MARYLAND PRINCE	GEORGE'S BR	ANDYWINE				1 ☐ Yes 2 ŽNo
	vith th	Director	10e. Street and Number		10f. Zip Cod		10g.	Citizen of What Co	
	eath v	erai	15713 BRANDYWINE	E ROAD  2. Was Decedent Ever in U.S.	206		acify Yes or No-	U.S.A	
936	should be filed within 72 hours after death with the Maryland nd Mental Hygiene marked other then "natural", or Items 23s or 28s-f show imatic event, the Medical Exeminer must be mailled at	by Funeral	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify C	of Hispanic Origin? (Spudan, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, White AMI	e, etc. ERICAN DIAN
5-0036	72 hor	ted	15. Decedent's Educ		a. Decedent's Usual Oc	cupation	ing 16b	. Kind of Business/	
2	ithin 700.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use ret	ne during most of work ired)			
2	filed w Hygier other th	S	17. Father's Name (First, Middle, Last)		HOMEMAKER	18 Mother's Name	(First, Middle, Maid	OWN HOMI	7
and	₽ E P S	To Be	WILIIAM JOSEPH	PROCTOR		CORA LI		on comano,	
Maryland 2121	should nd Men marks	Ĕ	19a. Informant's Name/Relationship (Typ		b. Mailing Address (Stre	-		y or Town, State, 2	Zip Code)
_	1 and 2 s Health ar Iom 27 le		JOHN R. LINKINS-	-SON 1	0505 CEDA	RVILLE RI	BRANDY	VINE, MD	20613
ore	S = 0		20a. Method of Disposition  X☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place	of Disposition (Name of ery, crematory or other p	place)		Location - City or	
altimore,	Pages ment of I		4 ☐ Donation 5 ☐ Other (Specify)	RESUR	ECTION CE		-29-06_CI	INTON	MARYLAND
Ball	permit. Page Dependent of Important: If any njury or once.		21. Signature of Funeral Service License	M0047	22. Name and Ad RAYMON	dress of Facility D FUNERAL	SERVICE	E, P.A:	
			23a. Part1. Enter the disease, or complic	cations that caused the death. Do					Approximate
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	- n				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	. SEPS	7			DAYS
ı	Examiner		D. Constitution and Miles	PNEUNOR	IA				0440
,	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
/	ficate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	n of h				
68760,	be ex icien burial			Due to for as a consequence	, or j.				
687	ficate physis the	edicai	<b>V</b> d					,	
P.O. Box	The law requires thet the deeth certis ate has been signed by the attending sege 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregna 5 Other (specify			23d. Date of del Month	ivery Day Year
	res thet igned b be deta	by Pr	Part II. Other significant conditions con			given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w require been sig should b	ed b	UNINARY TA	got infec	X TON		1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown
Division of Vital Records,	The law require has been bege 2 should	Completed					24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings available completion of cause of
ita	Attending Physician: The or death. ector: After this certificate his by the funeral director, pege by the funeral director.	ВеС	25. Was case referred to medical examiner?				n (Check only one)		
<u>5</u>	Physic this or	၉	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/O	outpatient 3 DOA	7	me 5 Residence		cify)
u C	ding f h. After funer	ion	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.	Injury \	njury at Nork? ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
İSİ	l or Attendation after deati	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, f			281. Location (Street	and Number or Ru	ural Route Number,
á	5 # 5 E	Certification:	4 Homicide	building, etc. (Specify)			City or Town, Si	ate) -	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the and/or investigation, in m	e time, date and place, ny opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier		29c. Lic	ense number		Date signed (Monta	-1 1
			1100		_   U	1877	1 AC	0071 4	-6,0006
	5		30 Name and address of person who con	(d.1) 1 -0 10	OLD CIA	IE CENTE	n wa	DELF.	26 , 2006 Ud . 2060
	Sta Registr		SEP 0 8 20	32. Registrar's Signature	Caroli s				

			State of Maryland / Department	artment of Health and Men rtificate of Death	tal Hygien	2006 28577
			Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physicia /Medic		Robert Joseph Lewis Tr		Month D	1
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			8867 SPARROW COURT	BEL ALTON		CHARLES
I	Funeral Director	•	5. Social Security Number 6. Sex $X \times X = 10^{-7}$ Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	Date of Birth Month, Day, Year JNE 27,	
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Manyl f sho	tor	MARYLAND CHARLES BEL A	LTON		1 ☐ Yes 2 🛱 No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	h with		8867 SPARROW COURT	20611		U.S.A.
	deat	Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. tten "neturel", or Itams 23a or 28e-f show tte Madical Examilier mast be malified at	by Fu	1 Never Married 2 Married 1 Yes 2\ No	1 ☐ Yes Ž∰No Specify:	.,,	Specific
Ö	hour: tural'	q pa	3 ☐ Widowed 4 Wivorced Year or Dates:  15. Decedent's Education 16a. Decedenty 15a. Decedenty 1	dent's Usual Occupation	16h	WHITE  Kind of Business/Industry
7.	nin 72 n *ne	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	, , ,	Table of Decimocomination y
212	giene giene	Com		CK DRIVER	s	AFEWAY
D D	al Hy d otha	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir		·
Maryland 21215-0036	2 should be filed wand Mental Hygien and Mental Hygien is marked othar traumatic event, In	2	ROBERT JOSEPH LEWIS, SR.	MILDREI		
Mar	d2sh hanc 7isn traum		19a. Informant's Name/Relationship (Type, Print)  ROBERT J. LEWIS, SRFATHER 886	ng Address <i>(Street and Number or Rural Ro</i> . 7 SDARROW COLLET . F	-	
	1 and Health tam 27 other tr		20a Method of Disposition 20b. Place of Dispo	sition (Name of Date	- 1	_ocation - City or Town, State
ltimore,	Pages nent of I int: If its iry or o		XLXBurial 2 Cremation 3 Hemoval from State	matory`or other place) NATIONAL CEM. 8-3	31 <b>-</b> 06 s	UTTLAND, MARYLAND
aĦ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar then "netural; or Items 23a or 28e-f show any injury or other traumatic event, the Marical Examiner must be natified at Once.		21, Signature of Funeral Service Licenses	2. Name and Address of Facility	130	
<u></u>	20E 20		Muchael O. F.	RAYMOND FUNERAL S <del>LA PLATA, MARYLA</del> N	ID 2064	
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause or each line.	er the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset and Death
E	Pnysician			erebrounscular Dise		2 years
	/Medical Examiner		Due to (or as a consequence of):			10
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			10 years
V	cuted	Examiner	trial initiation events	) TC		Syears
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
3876	icate t	dical	d			<u> </u>
Box 6	certif nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m m	that the death certifi ed by the attending I detached for use as	by Physician/Me	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	at the by the	hys	9 ☐ Unknown 9☐ Unknown		and British	
ري ص	res tha signed be del	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	1 Yes	use contribute to the cause of death?
0.00	w require been sig should t	eted	Hyperlipidemia		24a. Wasan	
Records,	<b>sician</b> : The law s certificate has t lirector, page 2 s	Completed			autopsy performed?	
Vital	Physician: The this certificate har all director, page		25. Was case referred to medical	26, Place of Death (Ch	1 Yes 2	o 1 Yes 2 No
>	ysicia is cert direct	To Be	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatier	Other		6 □Other (Specify)
0	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time o	f 28c. Injury at 28d. Work?	Describe how inj	ury occurred
Sio	lendir eath. or: Al	catlo	2 Accident investigation	M 1 Yes 2 No		
Division of	To the Hospitel or Attending F within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, deat			
	ha Ho in 24 I he Fu pletel	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred a		
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
•			Chlift. Challe m	D0030484		8/25/2006
	6		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 88 exon Itill Rd #	24U 11.	n 74 1/1 1/2 3 mater
LA.	Sta	te	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	TAUN ITLE ICK 4	107 CX	m 11.11 IND 20143
	Registi		31. Date filed (Month, Day, Year)  SEP 0 8 2006  32. pegistrar's Signature	sell)		

		For State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and N	Mental Hygie	211116 28578
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     JONG HA LEE	Al- Cit. Tours and continue of Double	2. Date of Death Month AUGUST	Day Year 3. Time of Death 3:00 a M
Examin Funeral	er	103 ENGLEFIELD DR  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  GAITHERSBURG  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death  MONTGOMERY  9. Birthplace (State or Foreign Country)
Director		219 88 9198 <sup>1</sup> X M 2 F 65 Yrs. Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc		DEC 3,	1940 S. KOREA
the Mary	Director	MD MONTGOMERY GAITHERS  10e. Street and Number	BURG	10a	1 ☐ Yes 2 ☐ No Citizen of What Country?
sath with	erai Di	103 ENGLEFIELD DR	20878	Ţ	JSA  14. Race - American Indian,
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "natural; or Items 23e or 28a-f show event, the Medical Examirar intention the incition and event, the Medical Examirar intention.	d by Funeral	Armed Forces? If  1 □ Never Married 2√2 Married 1 □ Yes 2 □ No	las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: ASIAN
filed within 72 h Hygiene. Ither than "natu	Completed	(Specify only highest grade completed) (Give kilfe. D	ent's Usual Occupation ind of work done during most of work O NOT use retired)	king	b. Kind of Business/Industry PRIVATE
d ta b	To Be C	17. Father's Name (First, Middle, Last)  KYU SOON LEE	JUM		WANG
Definitions, May year permit. Pages 1 and 2 should pearment of Health and Men importent: If item 27 is marke any injury or other treumstic. Once.			p Address (Street and Number or Rui ENGLEFIELD DR		
Pages 1 and of He		20a. Method of Disposition 1 ♥Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other Specify  GATE OF	atory or other place)		c. Location - City or Town, State  ILVER SPRING MD
permit. P Departm Importer any injur		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility CH 2303 KAYAK DR	IARLES H	INDS FUNERAL SERV
Physician		23a. Part1. Enter the hase in complications that caused the death. Do not enter shock, or heart failur historily one cause on each line.  Immediate Cause (Final disease or condition a	r the mode of lying, such as cardiac		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	4 Sion		
of CO, rate be executed hysicien and the burial-transit	Ical Examiner	Sequentially list conditions, Tury, leading to inimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
The Coll (43), F. C. BOX (05) (05)  The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit.	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed be should be detailed	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		2 No 3 Probably 4 Monknown
	Completed			24a. Was an autopsy performe	
the Hospital or Attending Physicien: The la in 24 hours after death. the Funeral Director: After this certificate has appliedly filled in by the funeral director, page 2	ıtlon; To Be	25. Was case referred to medical examiner?  1 Verse 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		th (Check only one) ome 5 (Hesideno 28d. Describe how	ee 6 Other (Specify) injury occurred
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
ne Hospi n 24 hour ne Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalid manner stated.	estigation, in my opinion, death occur	rred at the time, date	and place, and due to the cause(s)
To th To th comp	M	29b. Signature and title of certifier	29c. License number	290	Date signed (Month, Day, Year)
-8)		30. Name an ease of person who completes cause of death (Item 23a) (Type, F	Print)	e Prais	- 121 ) 200 k
Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 3 2006	E Brost Cl	A Edu	Date signed (Month, Day, Year)  8/21/2006  Chortug, Md, 2081

State of Maryland / Department of Health and Mental Hygiene 2006

			For State Registrar	State o	of Maryland	d / Depa <i>Cei</i>	artment of Hertificate of L	ealth and M Death	dental Hyg	jiene 20	06	28579
	Physici	an	1. Decedent's Name (First, Midd		m7	· · · · · · · · · · · · · · · · · · ·			2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	RENEE O 1  4a. Facility Name (If not institution				4b. City, Town, or	Location of Death	AUG. 2	1 200 4c. County		9:00 A M
			17 IDLEWILD		7 4 4	and the day of the same of	BETTER'	TON If Under 24 Hrs.	C D Dist	KENT		
ı	Funeral Director		5. Social Security Number 207-05-8384	6. Sex 1 □ M 2 F	7. Age (In yrs. I 90	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV • 1	1915	PENN	lace (State or Foreign http) SYLVANIA
	land		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	r, Town or Lo	cation				1	0d. Inside City Limits
	e Mary	ctor	MD KENT		В	ETTERT	ON					1 Taryes 2 □ No
	with the a or 28	Dire	10e. Street and Number 17 IDLEWILD D	RIVE			10f. Zip Code	0	1	l 0g. Citizen of \	What Cour	ntry?
10	72 hours eiter death with the Maryland natural', or iteme 23a or 28e-1 ehow dissal Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed Fo			Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
215-0036	nours e	d by	3 XWidowed 4 □ Divorce	If Voc Gi	ve		1□Yes 2ŽLNo	Specify:		Specify	/: V	HITE
15-(	in 72 t	piete	(Specify only high	est grade completed)		16a. Dece (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ring	16b. Kind of B	usiness/In	dustry
2	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (	1-40r 5+)	Н	MEMAKER			OWN H		
and	uld be til Mentel H rrked ott	To Be	17. Father's Name (First, Middle JOSEPH O'ROUF					18. Mother's Nam EDNA	e (First, Middle, : YOCUM	Maiden Suman	10)	
Maryland	S P E	<b>J</b>	19a. Informant's Name/Relation RICHARD KRAMER				ng Address (Street a				State, Zip	Code)
Baltimore,	permit. Pages 1 and 2: Department of Health at Important; if item 27 ie eny injury or other treu		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 4 ☐ Donation 5 ☐ Other (		State CHE	smetery, cret SAPEAR	sition (Name of matory or other place XE CREMATI	9)	Date 5-2006	20c. Location -		
Bait	permit. Depertr Import		21. Signature of Funeral Service	e Licensee/	rbeid	TER FI 13	Name and Address BO SPEER F	FENBEIN ROAD, CHE	& NEWNAL	M FUNER	AL HC 1620	ME, P.A.
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart lailure. List immediate Cause (Final disease or condition resulting in death)	a	caused the death each line.	eli	er the mode of dying		or respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a consequ		<u> </u>					
Ć.	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	uence of):						
68760,	cate be physicie the bur	dicai		d						-		
P.O. Box 6	death certifi e attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live !	tcome of pregna birth 2 ☐ Fetal nant at time of de lown	death 3	Ectopic pregnancy Other (specify)			23d. Da Mo	te of delive	ory Day Year
	w requires thet the been signed by th should be deteche		Part II. Other significant condi	tions contributing to d	leath but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did to	_ 1	nbute to th 3 □ Prob	ne cause of death? ably 4 □Unknown
al Records,	The law ete has b page 2 si	Completed							24a. Was a autops perfor 1  Yes	med?	prior to con death?	psy findings available noletion of cause of 2000 No
Vital	Phyaicien: rthis certific ral director.	To Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA Othe	26. Place of Deat		ence 6 □Oth	or (Coocid	
n of	Dn 00 00		27. Manne <del>r of</del> Death 1 Natural 5 ☐ Pend	28a. Date		28b. Time of	28c. Injury Work	at ?	28d. Describe h			7
Division	r Attending er death. rector: After by the fune	Certification:	2 Accident inves	tigation d not be 28e. Place	e of Injury - At ho ling, etc. (Specify	me, farm, str	M 1 7	es 2 □No	28f. Location (S. City or Town	treet and Numb	er or Rura	l Route Number,
۵	To the Hospitel or Attendin within 24 hours efter death. To the Funeral Director: Att completely filled in by the fun		29a. Certifier 1 Certify	ing Physician: To the	a best of my know	wledge deat	n occurred at the time	e, date and place,	and due to the c	ause/s) and ma	inner as si	ated.
	thin 24 thin 24 the Fu	Medical	(Check only 2 Medics one)  29b. Signature and title of certif		ner stated.	lion and/or in	vestigation, in my op			ate and place,		
	F 3 F 8		> Muly	ul E	~		- Do	0603		8/2	3/01	,
	Pi Sta	to	30. Name find address of perso M. CHAS Y 31. Date liled (Month, Day, Yea	GIMER	se of death (Item	199 S	Siezu R	a) Sies	5 CH	STEN	Pou	m, M)
	Registi		AUG	2 5 2006	Margar .	M	100					

DHMH 17 Rev 1/2001

28580 State of Maryland / Department of Health and Mental Hygien ? 11 15 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Physician 2134 P M 2006 August James Roger Mendenhall /Medical 4c. County of Death 4b. City, Town, or Location of Dealh 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | SEPT 11, 1927 9 Birtholace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Mary Land 1**∑**M 2□F 78 162-28-1273 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or Itama 23a or 28a-1 ehow the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director E1kton Ceci1 Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 21921 3474 Blue Ball Road 12. Was Decedent Ever in U.S. Armed Forces? WW II 1 XYes 2 □ No and If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Pages 1 and 2 should be filed within 72 thent of Health and Mental Hygiene. Int: If Item 27 is marked other then "nati (Specify only highest grade completed) Automotive/Tractor College (1-4or 5+) Elementary/Secondary (0-12) 12 Owner/Operator Repair other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maybelle Martindell James H. Mendenhall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3474 Blue Ball Road, Elkton, Maryland 21921 Dorothy F. Mendenhall/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition September 1 

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) permit. Pages Depertment of Important: If It any injury or o Rose Bank Cemetery 5, 2006 Calvert, Maryland P.A. Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 yrs oronary Or **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ty perchole to (o) as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did Iobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □ nknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has t 1□ Yes 2 No this certificate or Attending Physician: 26. Place of Death Check only one 25 Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient R/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this c 2 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 🗆 No death. investigation 2 Accident within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier D44716 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 11 Hig Elkbu 31. Date filed (Month, Day, Year) 16. State

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2006

	1- For State of Maryland / D	Department of Health and I Certificate of Death	Mental Hygiene 2006	28581
Physician	1. Decedent's Name (First, Middle, Last)  Garnetta Cline McCo	omas	2. Date of Death Month Day Year August 31 2006	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital	4b. City, Town, or Location of Death Havre de Grace	4c. County of Death	2210 1
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 80			e (State or Foreign nia
AA/U  1036  Ours after deeth with the Maryland ret; or iteme 23e or 28e-1 ehow Examinat must be notified at 1 by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Maryland Harford Abero  10e. Street and Number  37 Graceford Drive  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 12 Yes 2 WNo	10f. Zip Code  21001  13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert	10g. Citizen of What Country  United Stat  Decify Yes or No- Pican, etc.)  14. Race - American Black, White, etc.	es Indian,
nd 21215-0 nd 21215-0 se filed within 72 h lal Hygiene. d other than "natu event, tra Medical Be Completed	3 Widowed 4 Divorced Pyer or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)		Government  ne (First, Middle, Maiden Sumame)	try
Aaryla Aaryla 2 should I 2 should I 3 marke reumatic	I .		ral Route Number, City or Town, State, Zip Co	de)
Baltimore, Mispermit. Pages 1 and 2 Department of Health important; if them 27 important	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of camerier Gilplr	al Park 6, 2	Date 20c. Location City or Town,	land
8760, cate be executed bhysicien and the burial-transit dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if arry, leaduring to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of t	Tschemia	Int	proximate erval Between nset and Death
I RECORDS, P.O. BOX 61 The law requires that the death certific site has been signed by the attending page 2 should be detached for use as is completed by Physician/Mec.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Da	y Year
Cords, Portequires that wrequires that should be detti	Part II. Other significent conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the c	/
I Records, II Records, The law requires to page 2 should be			24a. Was an autopsy prior to comple death?  1 Yes 2 No 1 Yes 2**	findings available etion of cause of
ision of Vital Rudeath.  tor. After this certificate he the funeral director, page	25. Was case referred to medical examiner?  1	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
Division of the or Attending P is effect death. at Director: After the funers ed in by the funers Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Ro City or Town, State)	oute Number,
Divisit To the Hospital or Attent within 24 hours eiter deaut to the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge of my knowledge on the basis of examination and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	and due to the cause(s) and manner as state red at the time, date and place, and due to the 29d. Date signed (Month, Day	cause(s)
	30. Name and access of person who completed cause of death (Item 23a) (	D0062903	09/01/06	
State Registrar	31. Date filed (Month, Day, Year)  SEP 0 8 2006	19 Dunion Ave	Havre De Gruce,	UD 21678

				For State Registrar	Stat	e of M	larylan		partment ertificate			ınd M	lental Hy	giene Reg. No	006	28582
		Physici	20	1. Decedent's Name (First, Midd	le, Last)								2. Date of De	ath Day	Year	3. Time of Death
		/Medic		WILLIS P. MC									2. Date of De	31	06	/35 AM
		Examin	er	4a. Facility Name (If not institution	1		. 1		. 7		Location of			4c. Co	unty of Death	)
				CITIZENS	NURSI		Hoi			AUR	If Under 2		RACE		/	ond
		Funeral Director		5. Social Security Number 217–03–2051	6. Sex 1 1 M 2		ge (In yrs. 92	rast birtna Yrs	Months		Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)		place (State or Foreign ntry)
				Usual Residence of Decedent	7.								8/21/1	914	Mar	yland
		ylanc how		10a. State 10b. County	/		10c. Cit	y, Town o	Location						1	0d. Inside City Limits
		ith the Marylan or 28a-f show	ctor	MD Harfo	rd		Da	arlin	gton							1 ☐ Yes 2 XNo
		or 28	Oire	10e. Street and Number	_				10f. Zip					-	of What Cou	ntry?
		72 hours after death with the Maryland Instural', or Items 23s or 28s-f show dical Examinat must be notified at	Funeral Director	3304 Jourdan						21034					SA 	
		er de	nue	11. Marital Status	12. Was	Decedent	t Ever in U ?	.S. 1	<ol><li>Was Deced If Yes, spec</li></ol>	ent of Hi	spanic Orig n, Mexican,	jin? (Spe . Puerto	ecify Yes or No Rican, etc.)	14.	Race - Ameni Black, White,	
	36	rs aft	by F	Main Never Married 2 Main Main Main Main Main Main Main Main	ried 1 tyl	Yes 2 ☐ es, Give ror Dates:	NO 10/13	-16	1 ☐ Yes 2	2 ₹ No	Specify:			Sp	ecify: V	Mhite
	8	2 hou			nt's Education		1 343	16a. De	cedent's Usua	l Occupa	ition			16b. Kind	of Business/In	dustry
	215	within 73 ene. than "na	Completed	(Specify only higher Elementary/Secondary (0-12)		eted) ege (1-4or	5+)	(G lif	ive kind of wor B. DO NOT us	k done d e retired,	'u <i>ring</i> most )	of worki	ng			
	21	od with	Com	12		090 (1 401		Ass	istant	Ope:	cator			Pub	lic Uti	.lity
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinational be notified at once.	To Be (	17. Father's Name (First, Middle, Edwin T. McNutt									(First, Middle) wadde11		mame)	
	ary	shoul nd M	+	19a. Informant's Name/Relation	ship <i>(Type, Prin</i>	t)		19b. M	ailing Address	(Street a	nd Number	r or Rura	i Route Numb	er, City or To	own, State, Zip	Code)
		and 2 ealth a n 27 ig		Sarah Brown/Sis	ter			223	3 01d (	Quake	er Roa	ad,	Darling	gton,	MD 210	)34
	Jre,	of Hei		20a. Method of Disposition				lace of Di emetery, o	sposition (Namerematory or of	ne of ther place	9)	0	ate	20c. Local	ion - City or To	own, State
	Ē	Pages nent of I ant: If Its ury or o		1 ▼Burial 2 □ Cremation  1 □ Donation 5 □ Other (	3 ∐Hemovai Specify)	from State	Da:	rling	ton Cen	nete	cy   9	9/5/	2006	Dar1i	ngton,	MD
	Baltimore,	permit. Departr Importa any inja		21. Signature of Funeral Service	License	4	0	1	22. Name and Harkins		,		e, Inc.	. Del	ta. PA	17314
				23a Part1. Eprer the disease, o	r complications	that cause	d the deal									Approximate
_				Immediate Cause (Final	t only one cause	on each	line.	11.1	1 R	MAN	1/1	1	11/1	16/10	<	Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	a	ue to (or a	s a consed	uence of):	6 0	Toc	11	W/14	100414	2017	2	tok.
		Examiner						,								
	<b>.</b>		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	ue to (or as	s a conseq	uence of):								
-	1	ate be executed hysician and the burial-transit	Examiner	that initiated events	) c											
	90,	e exe cian a urial-		resulting in death) Last	Di	ue to (or as	s a conseq	uence of):								
0 1	8760	cate b	dlca		d											
15	9 ×	ding p	/Me	IF FEMALE:	23c If ve	s, outcome	e of pregna	ancw.								
-	Во	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 🗀	Live birth Pregnant a	2 Feta	I death	3 □Ectopic pre					230	. Date of delive Month	Day Year
2	o.	it the d by the tached	yslo	1 □ Yes 2 □ No 9 □ Unknown		Unknown	at time or d	Call	0 (10) (3pe							
-	<b>T</b>	uires that signed b d be deta	by P	Part II. Other significant condition	ons contributing	g to death i	but not res	ulting in th	underlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to tl	ne cause of death?
<u>`</u>	rds	quires an signe uld be											10	Yes 2□N	io 3□Prob	ably 4 Unknown
, )	Record	aw requir ts been si 2 should	plet										24a. Was		4b. Were auto	psy findings available
0		The lav	Completed										autor perfo	osy rmed? 200 No	death?	inpletion of cause of
h	Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?	al						26. Place	of Death	(Check only o	1		20.0
1	of V	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 No	Hospital:	1 🗌 Inpati	ient 2 🗆	ER/Outpa	ient 3 DO	A Othe	42	ling Hor	ne 5 🗆 Resi	dence 6	Other (Specif	y)
5		ding PI		27. Manner of Death  1 Natural 5 ☐ Pendi	28a.	Date of Inj (Month, Da	ury a <i>y Year)</i>	28b. Timi Injur		Bc. Injury Work			28d. Describe l	how injury o	ccurred	
5.	sio	Attending r death, sector: After by the funer	catl	2 Accident invest	igation not be				М		es 2□N					
C	Division	To the Hospital or Attending Physician: Within 24 hours after death, Confinite Funeral Director After this certific completely filled in by the funeral director.	Certification:		nined 28e.	Place of In building, e	itc. (Specif	ome, tarm,	street, factory,	, office		4	City or Tox		umber or Hura	il Route Number,
D		ospita hours uneral ly filler		29a. Certifier 1/2 Certifyi	ng Physician:	To the best	of my kno	wledge, de	eath occurred a	at the tim	e, date and	place, a	and due to the	cause(s) an	d manner as s	ated.
		the Hin 24 the Fi	edical	one)		manner s	tated.	tion and/o				n occurre				``
		S T X S	Σ	29b. Signature and title of certific		/_	110		29c.	. License	number	10	a	29d. Date s	igned (Month,	Day, Year)
	•	5		/ Amas A	1 mg	01				_	720	000		_9//	1100	
		1)		30. Name d address of person	who completed	Cause of	death (Iten	3/ (T	e, Priv(I)	111	War.	As of	60	061	1 CAM	1101-1001
		Sta	to	31. Date filed (Month, Day, Year	)	32. P	rar's Signa	ture	OUD AT			11.4.69	1	- 1	CONCA	men 210 B
	:··	Registr		SEP 0		Street		H,	mile	,			/			

Please Type or Print in Black Indelible Ink
State of Manyland / Department of Health and Mental Hygiene

THITIOTIY VV. IVIE	1	1- For State Certificate of Death Registrer	Reg	a No. 2001	2858
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Anthony Wayne Mealo	2. Date of Death Month August 29,		3. Time or Death 0749 hrs
,		4a. Facility Name (if not institution, give street and number)  Frederick Memorial Hospital  4b. City, Town, or Location of Frederick		4c. County of Death Frederick	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 216-11-8978 XX M 2 F 36 Yrs. Months Days Hours	8. Date of Birth Sept. 1	1969 Soul	place (State or ntryMaryland
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a State 10b, County 10c City, Town or Location  Maryland Frederick Frederick			10d. Inside City Limits 1 XXYes 2 No
th the Marylar 23a or 28a-fs notified at on	Dire	10e. Street and Number 32 East Fourth Street 21701	10	g. Citizen of What Coun U.S.A.	ry?
rr death wr or items	Fune	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Specify Cuban, Mexican, F		14. Race - Americ White, etc. Specify: Whi	
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) +5  Facility Accountary	se retired)	Nursing Ho	·
21215-0036 Muld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last)  Ronald Mealo	Name (First, Middle, M. Martha Wal		
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental 1: If item 27 is marked other traumatic event,		19a. Informant's Name/Relationship (Type, Print)  Jo Anne Mealo, wife  19b. Mailing Address (Street and Numb 32 East 4th Street	t, Frederic	k, MD 21701	-
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other Specify:	ept. 2, 2006	Smithsburg	
		21. Signature of Funeral Service Licensee  MO0255  2 Reme and Address of Ballis and Ballis Ballis 106 East Church  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car	n St., Fred	erick, MD 2	21701 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive cardiovascular disease or condition resulting in death)  Due to (or as a consequence of):			Between Onset and Death
4	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of):			
760, cate be exe physician he burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	6 TT	23d. Date of delivery	
Box 687 e death certific the attending s	sician/	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic past 12 months?  4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month D	ay Year
i, P.O. B ires that the d signed by the be detached	by Phy			pacco use contribute to t	
cords  law requi  has been 2 should	Completed	Obesity, ascilla	24a Was a autops perform	prior to co ned? death?	opsy findings available impletion of cause of
tal Recieian: The certificate	Be Co	25. Was case referred to medical 26.Place of Death (Control of Dea	Check only one)	No 1 Yes	2 No
of Vit ling Physic After this	T <sub>0</sub>	1 Ves 2 No Impatient 2 Enroutpatient 3 DOA 4	•	Residence 6 Other: ow injury occurred	
Sion Attendin r death. ector: A	cation	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 1	6545-7-75	to at and Novel are a Divi	al Ray da Niyeahoa Ciby
Divis pital or / ours after teral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	or Town, St	treet and Number or Rur ate)	ar Route Number, Oity
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C			and place, and due to the	cause(s)
	Š	29c. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Mon August 30, 2006	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	21201		
	tate	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis					

		1	For State Registrar	•	artment of Health and Martificate of Death	Reg. N	2006 28384
П	Physicia		1. Decedent's Name (First, Middle, Last)  WILLIE MAE MCM	IANUS		2. Date of Death Month August 20	3. Time of Death 3. 2006 1:36am M
	/Medic Examin		la. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		4c. County of Death
			Southern Maryland Hosps 5. Social Security Number 6. Sex	ital 7. Age (In yrs. last birthday)	Clinton  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Prince Georges  9. Birthplace (State or Foreign Country)
Н	Funeral Director		577-54-3238		Months Days Hours Min.	(Month, Day, Year Feb 13,19	018 S. Carolina
	and	H	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryl	tor	Md. Prince George	es Fort Was	hington		1. Yes 2 □ No
	in the	Director	10e. Street and Number		10f. Zip Code	1	Citizen of What Country?
	ns 23e	Funeral		ecedent Ever in U.S. 13. \	20744  Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto		3 · A · 14. Race · American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural; or items 23a or 28e-f show empty injury or other treumetic event, I'te Medical Examinar must be notified at Once.	by Fun	1 Never Married 2 Married 1 Yes,	es 2⊠No	If Yes, specify Cuban, Mexican, Puerion 1 ☐ Yes 2 🛣 No Specify:	o Hican, etc.)	Specify: Black
21215-0036	n 72 ho "netur edical	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
2	d within	omo	Elementary/Secondary (0-12) Colleg 5th	e (1-4or 5+)	ry AIde	Pr	rivate
Maryland	be file ntal Hy ad othe event,	Be (	17. Father's Name (First, Middle, Last)  Lawrence Harling		18. Mother's Nan	ne <i>(First, Middl</i> e, <i>Maid</i> Butler	ən Sumame)
aryle	should nd Mer marke	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Ru		y or Town, State, Zip Code)
, M	and 2 ealth a m 27 is		Corrine Hawkins/Daugh		Belfast Drive, I		1d. 20744 Location - City or Town, State
Baltimore,	ages 1 nt of H t: if iten / or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fr  4 □ Donation 5 □ Other (Specify)	om State	osition (Name of matory or other place)  em.Pk 8/26/		ndover Md.
altiu	mit. P partme porten y injury	1	21. Signature of F. neral Service Licensee	Harmony M	$em_{\bullet}PK$ 6/20/ 2. Name and Address of Facility $J_0$		
8	8 8 1 2 2		23a. Part / Enter the disease, or complications to	EN 171	6 Kennedy St., N	.W. Wash. I	O.c. 20011 Approximate
	Pnysician /Medical	N. C.	shoot, or heart failure. List only one cause Immediate Cause (Final disease or condition	on each line.  No Crotic  to (or as a consequence of):	infected D	club itu	Interval Batween Onset and Death Oncet Colors
	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate Due	e to (or as a consequence of):	of Cellulity	,	anthro y
,0,	ficate be executed physician and is the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Sac. e to (or as a consequence of):	I osteomy	liks	combrow w
68760,	ficate b physic s the b	edica	d				
.O. Box	uires that the death certific signed by the attending I d be detached for use as	Physician/M	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, D	law requires that the as been signed by th 2 should be detache	b	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Record	9 C B	Completed	CASTRITS			24a. Was an autopsy performed	
of Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		Other	ath (Check only one)	
n of \	ng Physicien: viter this certific uneral director,	on; To	27 Manne I Death 28a, D	1 ☑npatient 2 ☐ ER/Outpatien Date of Injury Month, Day Year) 28b. Time of Injury		dome 5 ☐ Residence 28d. Describe how in	e 6 ☐ Other (Specify)  njury occurred
Division	or Attending Physicien: after death. Director: After this certific I in by the funeral director.	Certification;		Place of Injury - At home, farm, st uilding, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	Hospite 4 hours Funerei	edical Co	(Check only 2 Medical Examiner: On t	o the best of my knowledge, dear he basis of examination and/or in manner stated.	th occurred at the time, date and place envestigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ceptifier		29c. License number	29d.	Date signed (Month, Day, Year)
)			> traffyrden	-MD	50454	H	24,24,66
2	-4		agellation its	cause of death (Item 23a) (Type	1 Silver SDR	The mo	20902
	St. Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5 2006	32. Registrar's Signature	W	7	

State of Maryland / Department of Health and Mental Hygiene 2006 28585 1 - Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 4:45P August William C. May, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Bradford Oaks Nursing Home Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F Months Days Hours Yrs Director Nov. 14, 1921 North Carolina 84 577-20-5903 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits in then "natural", or Itame 23a or 28a-f ehow the Medical Exercines must be notified at 1 X Yes 2 □ No Directo Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 United States 3313 Dallas Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If tiem 27 ie marked other then "natural", or Itar any injury or other traumatic event, the Medical Examinal once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: **Black** þ 3 ☐ Widowed 4 █ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 9th Labor Private 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Polly Ann Hardy William C. May, Sr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2642 Birney Place, SE, #101 Wash., DC 20020 Richard E. May/Brother 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/2006 Lee's Crematory Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Xili 2 Kin 4001 Benning Rd., NE Wash., DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease Approximate Intervat Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No o Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic right foot ulcer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has l lirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 Director: After the 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 🗀 Accident 6 Could not be 3 M Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Junio D35206 August 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tanner, M.D. 11701 Livingston Rd., #101, Ft. Wash., MD 20744 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 2 3 2006 Registrar

			For State Registrar	State of Marylar		artment of He tificate of De		∕lental Hygie Reg	ene 2006	28586
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last</i> Richard Ar		chee1			2. Date of Death Month August 2.	5 <sup>Day</sup> 2006 <sup>Year</sup>	3. Time of Death 7:20 р м
	Examir		4a. Facility Name (If not institution, give Charlotte Hall Ve			4b. City, Town, or Lo			4c. County of Death St. Mary	
	Funeral Director		5. Social Security Number 6. Se 478–18–8889	x	last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Dec. 19,	9. Birth	pplace (State or Foreign intry) OWA
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Ba-f e	Director	Maryland St. Mar	y's (	Charlot	te Hall	·			1 ☐ Yes 2 ☐ No
	th with the		10e. Street and Number 29449 Charlotte H	all Road		10f. Zip Code 20622		10g	USA	untry?
936	urs after deal	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban, ☐ Yes 2점 No	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f ehow other traumatic event, Ite Medical Examinational Landilled at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupation kind of work done during OO NOT use retired)  Lawyer	on ing most of work	king	b. Kind of Business/I	
<u>ام</u>	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)				8. Mother's Nam	e (First, Middle, Ma		
ylai	should be and Mental marked c	To	Herman P.	Micheel			Katheri		McCarthy	
a N	and 2 st salth and n 27 le n		19a. Informant's Name/Relationship (T) Pam Tiernan/Daugh			g Address <i>(Street and</i> Iyndham Woo			-	
ore,	jes 1 and of Health if item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. F		sition (Name of natory or other place)		Date 20	c. Location - City or T	
altimore,	permit. Pages Department of I Important: If its eny Injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Br		d-Echols (	OT .	72006 Ch	narlotte H	all, MD
 Ba	Dep Impo		Four Ba	I John		insfield-E		Correl Holl	me MDP 2062	2
	Disconicion		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that caused the deat ne cause on each line.	^			or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence or):	diomyo	s patu	y		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq		nonale				
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pulmono		Hyper	tens	ion		
68760,	ficate be executed physicien and is the burial-transit	edicai E	L,	Due to (or as a conseq	$\sim$	Hypen vteny d	i'sease			
O. Box 6	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	I death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive	very Day Year
ds, P.	uires that the de	۵	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause given i	in Part I.		co use contribute to	~
Division of Vital Records,	Physician: The law require this certificate has been sid al director, page 2 should b	Completed	Clostridium	difficile	e Co	eitile		24a. Was an autopsy performed	d? prior to co	opsy findings available ompletion of cause of
Ita	ertifice actor, p	BeC	25. Was case referred to medical examiner?				6. Place of Deat	1 ☐ Yes 2 ☐ h   Check only one	No 1 ☐ Yes	Z NO
ō	Physi r this o	<u>ار</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of			ome 5 Residence	e 6 Other (Speci	fy)
Sion	Attending Physician: It death. Sector: After this certifict by the funeral director,	ation	1 Naturaf 5 Pending investigation	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	2 □ No		, , , , , , , , , , , , , , , , , , , ,	
Ž Ž	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, estigation, in my opini	date and place, ion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	M		29c. License nu			Date signed (Month,	
1			30. Name and address of person wh	Atamus less cause of death (Item	232) (Tune 1	1 D450	192	8	128/20	006
			110 Hospital (5	oad Sui	te #	205 P	rince	Fred ri	ich, 1	006 1D 20678
	Sta Registr	1	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Luck				

John Vincent Mebley 06-06194 UNK UNK

Please Type or Print in Black Indelible Ink

riease	Type of Fillicia black indelible link
State of Marylan	d / Department of Health and Mental Hygien

2006 28587

	1- For State Registrar	Certit	ficate of Death		Reg. I	<b>2</b> U	06 285
Physician	1. Decedent's Name (First, Midd	ile,Last)			2 Date of Death Month Da		3. Time of Death
dical Examine	Vincent DePa	ul Medley			August 19, 2	006	0210 hrs
	4a. Facility Name (if not instituti	· <del>-</del>		r Location of Death	1	4c. County of Dea	ath
	Dares Beach Road @		Prince Free			Calvert	
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs. last	birthday) If Under 1 Ye.  Months Da		<del>_</del>	MM/DD/YYYY) 9. E Fore	eian
Director	212-86-3503	1XM 2F 42	Yrs. Workins Da	ys Hours Will	03/06/1	964	Country)Maryland
	Usual Residence of Decedent						
any	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limit
od show	Maryland Saint	Marvs Lex	ington Park				1 Yes 2 X N
daryland 28a-f show d at once.	10e. Street and Number	Harys I hex	10f. Zip Code		10g.	Citizen of What Co	ountry?
th the Maryland  23a or 28a-f sho  10 in orther	005/5 0 1 1	:11 D4	2065	. 2		USA	
5-0036 led within 72 hours after death with the Maryland stygene the stydent of the Medical Examiner must be notified at once the must be notified at once the must be notified at once the must be notified a		12. Was Decedent Ever in U.S.	13. Was Decedent of H		pecify Yes or No-		erican Indian, Black,
or items 23	1 X Never Married 2 N	Armed Forces?	If Yes, specify Cuba			White, etc.	
er de		1 Yes 2 X No	1 Yes 2 X N	o specify:		Specify: B1a	nck
rs aft	45 December 1/2 Education / St.	or Dates:	6a. Decedent's Usual Occupa		work done 16	b. Kind of Busines	
"nat	Elementary/Secondary (0-12		during most of working life				•
21215-0036 uld be filed within 7: Mental Hygiene. marked other than c event, the Medical			Carpenter			Construct	tion
Siene Brench	17. Father's Name (First, Middle		Carpenter	18.Mother's Nam	e (First, Middle, Maio		LIOII
				Marv	Loretta	Winters	
ould be filed within 7, and the filed within 7, and Mental Hygiene.  S marked other than ite event, the Medical		ship (Type Print )	19b. Mailing Address (Stre				ite, Zip Code)
MD 3	-		300 Wildflowe				, , ,
and 2 and 2 ealth tem 2 traun	Carolyn Johnson		ace of Disposition (Name of Co			Oc. Location - City	or Town, State
of H	1 XBurial 2 Crematic	ii b   Iteliioval liolii olale	ematory or other place)				
Pag ment tant:	4 Donation 5 Other S	pecify:	n of Peace Cemete		ust 26 2006	Helen ,	, Maryland
Baltimore, MD 2121 pernit. Pages I and 2 should be fi pergentered (Health and Mental Important: If item 27 is markete injury or other traumatic event.	21. Signature of Funeral Service	Licensee	22. Name and Addres	•	1 17	D. 4	
<b>m</b> 855.5	Thickard Kevi	a Hardeni	Mattingley-(	nwick Street	t Leonard	town; Mary	
Physician	23a. Part I. Enter the dise se, of failure. List only one caus.	r complications that caused the ath. D	o not enter the mode of dying	g, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interv Between Onset an
/Medical Examiner	Immediate Cause (Final diseas	M 1, 131 T 0 .1					Death
Zammer	or condition resulting in death)	Due to (or as a consequence of):					
i	Sequentially list conditions,	b					
	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
ted 1 insit	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):					
		d.					
760, icate be executed physician and the burial - transit	X UNPENDED  IF FEMALE: 23b, Was decedent pregnant in	X AMENDED, 7, 23a, 27, 28a	-f porME c86/	2/27/07 T	Г		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic or the Funeral Director after this certificate has been signed by the attending physicic or the Funeral director, page 2 should be detached for use as the burning of the funeral director, page 2 should be detached for use as the burning of the function of the	IF FEMALE:	23c If yes, outcome of pregnate	incv	2/21/01 1.		23d. Date of delive	erv
Box 68760 e death certificate be the attending physical for use as the bu		the 1 Live birth		Ectopic pregn	ancy	Month	Day Year
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Division of Vital Records, rat or Attending Physician: The law require rs after death  al Director: After this certificate has been si facility the funeral director, page 2 should be the fineral director, page 2 should be seen as a facility of the funeral director.					24a Was an		autopsy findings availab
COT law law has b	<u> </u>				autopsy performe		
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tal Historian: certific ector,	25. Was case referred to medic examiner?	Hoopital:		oe of Death (Check			
Lithis Lithing King	1 Yes 2 No		R/Outpatient 3 DOA			sidence 6 🗸 Oth	ner: Scene
n of ling Ph After Aneral	27. Manner of Death	28a. Date of Injury (Month, Day, Year)		ury at Work?	28d. Describe how	injury occurred	
tendi eath.	Natural 5 Pe	nding 8/19/2006 2	2:10 am   1_	Yes 2 X No	unk.		
ivision or Attene after death Director: I in by the		28e. Place of Injury - At hom	ne, farm, street, factory, office	building, etc.	28f. Location (Stre	et and Number or I	Rural Route Number, Ci ch Rd. & Armo
Divi	4 Homicide	ermined (Specify) local st	treet		Prince Free	derick, MD	CII Nu. & AIIIO
Hosp 24 ho Fune rely f	/9a Centrer .	Physician: To the best of my knowledge	e, death occurred at the time,	date and place, an	d due to the cause(s	) and manner as st	arted.
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Ex	aminer: On the basis of examination and	l/or investigation, in my opinio	on, death occurred	at the time, date and	d place, and due to	the cause(s)
To To	(Check only 1 Certifying one) 2 Medical Ex	and manner stated	29c Licer	nse number	2:	9d. Date signed (A	Month, Day, Year)
	1/1/	rasself MD	0.0	.M.E.		August 19, 200	
						5. 5. 5, 250	
		n who completed cause of death (Item 2:		Raltimore ME	21201		
	Melissa Brassell, MD			DaitiiTiOTE, IVIL	, 2 1201		
Sta	e 31. Date filed (Month, Day, Year	32. egistrar's Signature	Loute				
Daniata							

State of Maryland / Department of Health and Mental Hygiene 2006

1- State Amend#23a & #23b-remove per phys/fh 08-28-2006
Registrar Amend#23a & #23b-remove per phys/fh 08-28-2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Philip L. MacDonald August 20, 2006 2:55 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Edenton Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
October 7, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 50X 127M 2□F 007-07-6497 Director Nova Scotia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or itema 23s or 28s-f show other traumatic event, it a Madical Examinar must be multified at Frederick Maryland Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5911 Genesis Lane 21703 U.S.A. death \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: if item 27 is marked other then "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ № Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Radio Announcer Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Mac Donald Ethel Leith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4026 Ballanger Creek Pike, Frederick, Maryland 21703 Jill Horton - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2XCremation 3 ☐ Removal from State Frederick Crematory permit. Page Department of important: if eny injury or once. 8-23-2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Censee 22. Name and Address of Facility Stauffer Funeral Home Maron 1621 Opossumtown Pike, Frederick, Maryland 21702 Ellene Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia **Physician** Willemence /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) CLS 10 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death. Funeral Director; After the 28b. Time of 28d. Describe how injury occurred HUIK 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifier tang are helend and 2 not ed cause of death (Item 23a) (Type, Print) 31. Date filed (Fonth, State Registrar

			For State Registrar	State o	f Marylan		artment of tificate o				_	2006	28	589
	Dhuaiai		1. Decedent's Name (First, Middle, I	.ast)						2. Date of Dea	ath Day	Year	3. Time of	Death
	Physicia /Medic		Susanne M.							August	. 19	2006	5:08	РМ
j .	Examin	er	4a. Facility Name (If not institution, g Anne Arundel Med				4b. City, Town	Annapol	is		4c. Co	Anne	Arunde	<u> </u>
	Funeral Director		216-60-9390	Sex 1□M 2 F	7. Age (In yrs. 54	last birthday) Yrs.	If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birt (Month Da May 10	1952	Cour	olace (State o ntry) rmany	r Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	I 0d. Inside Ci	y Limits
	Maryl f sho	ğ	Maryland Anne A	runde1		Ann	apolis						1 🗆 Yes	2₹No
	r 28s	rec	10e. Street and Number				10f. Zip Cod	9			10g. Citizer	n of What Cour	ntry?	
	th wit	alD	228 Old Mill Bot	tom Road	, S.			21409			Unite	ed Stat	es	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Pratural; or items 21a or 28s-f show eny injury or other treumstic event, it a Medical Examinar must be notified at once.	by Funeral Directo	11. Marital Status  1 □ Never Married	Armed Fo	2 <b>X</b> No ve		Was Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: W		
21215-0036	hours tural	q pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or D	ates:	16a Dece	dent's Usual Oc	cupation			16h Kind	of Business/In		
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Maryland	Menti Menti arkec	2		ohn Shin	n					Maria Wo				
Jar	12 sh and rem		19a. Informant's Name/Relationship		J	1.				l Route Numbe				
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nor	ages nt of nt of t: if it		1 Burial 2XX remation 3		Siale		sition (Name of matory or other	1	0/12/	06				A
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ä	Depa Impo eny is		Mechel &	Y. KIL	Ha					er St.	-			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that only one cause on	caused the deat	h. Do not ent	er the mode of	tying, such as	cardiac o	or respiratory at	rest,		Approximate Interval Bets	ween
	Pnysician		Immediate Cause (Final disease or condition	-	Metasta	tic Ca	rcinoma						Onset and I	onth s
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):								
	Examiner	Ų.	Sequentially list conditions, if any, leading to immediate	b.	les as a casses	was all.								-
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Ν	Attending Physicien: r death. sctor: After this certific: by the funeral director.	ion:	27. Manner of □eath  Natural 5 □ Pending		of Injury oth, Day Year)	28b. Time o Injury		njury at Nork?		28d. Describe I	now injury o	ccurred		
isic	death death stor: ,	icat	2 Accident investiga 3 Suicide 6 Could no	t be 390 Place	e of Injury - At h	ome farm str		Yes 2		28f. Location (S	Street and I	Number or Bur	al Route Num	her
Division	after Direction by	Certification;	4 ☐ Homicide determin	build	ling, etc. (Specif	(y)	eet, lactory, on	00		City or Tov		Talliagor of Flanc	2, 7, 10 010 7, 10,71	561,
	To the Hospital or Attending Physicien: The I within 24 Junus after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier Cartifying (Check only one)	Physician: To the terminar: On the band man	e best of my kno pasis of examina ter stated.	owledge, deat ation and/or in	h occurred at th vestigation, in n	e time, date ar ny opinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) ar date and pi	id manner as s ace, and due t	tated, o the cause(s	)
	To the within 2 To the comple	Me	29b. Signature and title of gertifier	- A/	/		29c. Lic	ense number			29d. Date s	signed (Month,	Day, Year)	
)			) (m)	1 13K	~	W		D64379	9		8,	/19/200	6	
			30. Name and addr ss of person w	•			-		-	7 04	101			
	.5		Dr. Jay Rhee 31. Date filed (Month, Day, Year)	2001 Med	dical Pa		Annapo	ıls, Ma	aryıa	and 214	10 I			
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State of Maryland / Department of Health and Mental Hygiene 2006 28590 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician August 19, 2006 2:48P M John Michael Maxie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**∑**M 2□F May 15,1951 55 Mary land 212-58-7795 Director Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show in than "natural", or itams 23a or 28a-f showing Medical Examination as the Medical Examination as the motified at 17 Yes 2 No Anne Arundel Ann apolis Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 United States 918 Jackson Street filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Towing UNK Station Attendant other other traumatic avant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any jinry or other traumatic avant 2008. Be Lassie Bowlin မ Tyler Maxie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 918 Jackson Street, Annapolis, MD Betty Drury / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Gardens 8/24/06 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra abolominal wills Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit sician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ signe 1 be ( 1 Tes 2 No 3 Probably 4 Unknown Phenno na Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Renal failure 24a. Was an autopsy performed? Yes 202 No 1 ☐ Yes 2 ☐ No 1 Yes certificate tha Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide fo the within 24 hour.
\*ha Funaral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of criffier Study Relly TUD 29c. License number 29d. Date signed (Month, Day, Year) 8/19/06 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sjorlot Bell, ND 2001 Medical Vanhay anna polis, ND 31. Date filed (Month, Day, Year) gistrar's Signature AUG 23 2006 Registrar

		_	For State Registrar		State of I	Marylan				ealth a	and M		Reg. No.	2006		591
*	Physici	-	1. Decedent's Name (First, Mide		-	34	1	_ T_				2. Date of Dea	Day 20	2006	3. Time o	M
	/Medic	al	William  4a. Facility Name (If not institution		reet and numb		atthew			Location of	of Death	August		County of Death	3:27	р "
	Examin	er	1104 Niblick			,			no1d					Anne Ar	unde1	
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. i		If Unde	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	v. Year)	Cou	place (State ntry)	
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	land ow		10a. State 10b. Count	у		10c. City	y, Town or Lo	cation							10d. Inside C	City Limits
	a-feh	ior	MD Ann	e Aru	ınde1	4	Arno1d								1 🗌 Yes	2 <b>X</b> No
	or 28	Dire	10e. Street and Number	<b>a</b>	_				Code				10g. Citiz	en of What Cou USA	ntry?	
	e 23a	erai	1104 Niblick		2. Was Decede	ent Ever in II	C 13 1		21012		ain? (Sp	ecify Yes or No	- 1	4. Race - Ameri	can Indian.	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow any Injury or other traumatic event. I'm Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married XXMa 3 Widowed 4 Divorce	rned	Armed Force 1 Yes 2 If Yes, Give Year or Date	os? <b>CK</b> No		f Yes, spe	cify Cuba	n, Mexicar Specify:	, Puerto	Rican, etc.)		Black, White,		
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2	within one.	ig I	Elementary/Secondary (0-12)		College (1-4	or 5+)	Teac		se retired	()			Fdı	cation		
N O	filed v Hygie ther t		17. Father's Name (First, Middle	, Last)			Teac	iie i		18. Mothe	r's Name	e (First, Middle,				
<u>a</u>	id be lental rked o	To Be	William F. Ma	tthew	<b>v</b> s					Do	rotl	ny Grace	e Pra	atico		
Maryland	and N		19a, Informant's Name/Relation					•						Town, State, Zi	o Code)	
Σ.	and and mark		Betsy Matthew	tW) a	ife)	205 0						rnold, I			ours State	
Baltimore,	ges 1 nt of H i if ite or otl		20a. Method of Disposition 1 ☐ Burial 2XXCremation		emoval from St	119	Place of Dispo emetery, crei			1				cation - City or T		
፟	artmer artmer artant njury		4 Donation 5 Other			Met	ro Cre					-2006		imore,	MD	
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P.O. Box 68760,	death certific e attending p id for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d.		h 2∐Feta ntattime ofd	Ideath 3	Ectopic p		,			2	3d. Date of delik	very Day	Year
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<u> </u>	o :□	To B	examiner? 1 ☐ Yes 2 No		ospital: 1 🗆 Inp	atient 2	ER/Outpatie	nt 3 🗆 🗅	OA Oth	er	ursing Ho			S □Other (Spec	ify)	
o uo	Jing After fune		27. Manner of Death  1 Natural 5 Pend 2 Accident invest	ling tigation	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f M	28c. Injur Wor	yat k? Yes 2 □	No	28d. Describe	how injury	occurred		
Division of Vital	or Attendater dea	Certification;	3 Suicide 6 Coul	•	28e. Place o	f Injury - At h	ome, farm, st	reet, facto	ry, office			28f. Location ( City or To		d Number or Ru	ral Route Nu	mber,
	Hospital 24 hours a Funeral stely filled	Medical (				is of examina								and manner as place, and due		(s)
)	To the within 2 To the comple	Me	29b. Signatule and title of cert	Ro	UZR 1	MO		25	c. Licens	e number	64		29d. Dat	elsigned (Month	Day, Year)	2
	12		30. Name and address of person	mwho co	mpleted cause	of death (Iter	n 23a) (Type,	Print	M	AT	PF	130	Mon	LAPOZH	MM	140)
3	St Regist	ate rar	31. Date filed (Month, Day, Yea AUG 2	3 200		gistrar's Signa	ature	out	,				. 4.7		1	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Robert Raymond McCarthy 2006 21, 9:18 a August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 X M 2 □ F DC 81 Aug. 2, 1925 Washington, Director 579-26-4972 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Worle I 10b. County 10a. State rthan "natural", or Iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 KNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 2207 Henderson Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene, in matural, or lies any niury or other traumatic event, the Medical Extransactors. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No Specify: Specify: White WWII Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Municipal Government Firefighter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella T. Fitzgibbon Edward McCarthy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2207 Henderson Avenue, Silver Spring, MD 20902 Helen L. McCarthy/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 25. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2006 Silver Spring, Maryland 21. Signature of Puneral Service License Francis Address Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 Day Pnysician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 Years Chronic Obstructive Pulmonary Disease Sequentially list on citics if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown Restrictive Lung Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No this certificate 1 Yes 2 🖾 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire ို 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jot 024571 Hujust 23. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay Wer.

31. Date filed (Month, Day, Year)

AUG 24 6205919 11561 けして 32 Registrar's Signature State 24 2006

Registrar DHMH 17 Rev 1/2001

			1 State	partment of Health and Nertificate of Death		0000	
			Registrar  1. Decedent's Name (First, Middle, Last)	erincate of Death	Reg. 2. Date of Death	2000	3. Time of Death
	Physicia /Medic		Daisy May Miller			Day Year 2006	5 2:50 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Williamsport Nursing Home	Williamsport  Williamsport  If Under 1 Year   If Under 24 Hrs.	0 Date of Birth	Washing	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2XXF 7. Age (In yrs. last birthd 213-18-8579 86 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 23,1		place (State or Foreign ntry) ~y land
			Usual Residence of Decedent		Mug. 22,1		•
	arylan ehow	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	Directo	Maryland Washington Wil	l iamsport	100	Citizen of What Cou	
	3a or	급	316 S. Artizan St.	21795	log.	USA	,
	death	Funerai		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri Black, White,	
õ	or Ite		1 Never Married 2 Marned 1 Yes 2 No	1 ☐ Yes 2 No Specify:	, riiouri, oto.,	Specify:	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or terme 23a or 28a-f ehow int, the Madisal Examiner must be motified at	ed by		cedent's Usual Occupation	166	. Kind of Business/Ir	Vhite
<u>.</u>	nin 72 n "na Nadic	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work a. DO NOT use retired)	king	. Hill of Duomioodin	addity.
7	od with	EoC	5	Housekeeper		Hospi	tal
D D	d ta b	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Maryland	should by	ဥ	William Henry Gesford  19a. Informant's Name/Relationship (Type, Print)  19b. M	Beula		Bomberger	
<u>≅</u>	s 1 and 2 should t Health and Mer Item 27 ie marke other traumatic			Fair Meadows Blvd		5.5 -p.009	
ā,	s 1 ar		20a. Method of Disposition 20b. Place of Disposition			. Location - City or T	
Baltimore,	permit. Pages: Department of Important: If Ite eny injury or of		Manual 2 Cremation 3 Hemoval from State	wn Mem. Park Aug.28	3,2006 Wi	Hiamsport	t.Maryland
žait	permit. Departifications of the permit of th		21. Signature of Funeral Service closures	Caborae arune failin Hon	ne, P.A.		10
	₫ O E ● Ø		23a. Part1. Enjor the disease, or complications that caused the death. Do not	425 S. Conococheagu		liamsport	MD 21795 Approximate
			shock, of heart failure. List only one cause on each line.	0	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate/Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	bilateral			4 days
	Examiner		Asthma				years
	D =	ner	if any leading to immediate  Due to fur as a consequence of the conseq				<i>J</i>
	ecute and trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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28	death certiticate be executed e attanding physicien and of for use as the burral-transit		d				
ROX 6	leath certitic attanding pl	M/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ Ho o 9 ☐ Unknown  in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month	Day Year
J.	law requires thet the as been signed by th 2 should be detache	Ph)	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Division of Vital Records,	uires thei signed b	d by	Hupertension		1 ☐ Yes	2 No 3 Pro	bably 4 Blanknown
Ŝ	tw requir s been si should	Completed	Congestive Heart Failure	-	24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
ž	The lav	Ho	Alzheimers Disease		autopsy performed 1 Yes 2 1	d? death?	_
<u> </u>	ctor, p	Bec	25. Was case referred to medical		th (Check only one)		
5	Physiclan: r this certitic rat director,	ျှ	1 ☐ Yes 2 Tho Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ome 5 Residence		fy)
5	Ing Atte	tion:	27. Manny of Death  1 latural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how i	injury occurred	
	or Attending elter death. I Director: Alter d in by the fune	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	street, factory, office		t and Number or Run	al Route Number,
á	2 2 2 2	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town, S	rate)	
	Hospitel		29a. Certifier (Check only (Ch	satt conumed at the time, date and place, rinvestigation, in my opinion, death occur	and due to the caus	e(c) and manner act	tated. o the cause(s)
	To the Hospitel of within 24 hours eld To the Funeral D completely tilled in	Medical	one) and manner stated.		1	5	- V
	₹ ¥ 6		Cynthe Kittner-Sand	D D47451	Au	pust 25	2006
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	omo 151	No + P 1 -	tizan Stant
31	4-0		30. Name and address of person who completed cause of death (Item 23a) (Ty Cynthia Kuttner-Sands M) (Item 23a) (Tynthia Ku	nsport Nursing N	JW. III	MALLY YL	Maryland
ž,st	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.1.			
	Registr	ar	AUG 2 3 2000 Been 13.	Sperked			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28594 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:35 P M 2006 August Juanita N. Norris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 ☐XF Yrs. 82 20, 1923 Virginia 228-20-3978 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 11621 New Hampshire Ave. United States 2 should be filed within 72 hours after deeth is and Mental Hygiene.
Is marked other than "natural", or Itama 23 Completed by Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Private Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rowena Fuller Joy McGhee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 end 2 siment of Health an ant: If item 27 is 14237 Angelton Terrace, Burtonsville, MD 20866 K. Anthony Norris/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of the policy of the policy or poli Lincoln Memorial Cem. 8/23/2006 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee Wash., DC 20019 4001 Benning Rd., NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Mocardial Infanching and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 20 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by signt be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ No 24a. Was an 1 ☐ Yes 2 NO Division of Vital 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 patient 2 ER/Outpalient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28c. Injury at Work? 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/D Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year) AUG 2 5 2006

29b. Signature and title of certifier

32 Registrar's Signature

MANYIM.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADVENTIST HOSP, TAKEMA PORK

Registrar

State of Maryland / Department of Health and Mental Hygiene 28595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** 26, 5:40 A M 2006 June Marie Nestlebush August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 35695 Aviation Yacht Club Road Mechanicsville Saint Marys Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 . Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖫 F Vrs 81 Director 508-20-6848 April 26, 1925 Nebraska Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ehow 10a, State item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Modical Example of must be notified at 1 ☐ Yes 2X No Maryland Saint Marys Mechanicsville Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 35695 Aviation Yacht Club Road USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be tiled within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item eny injury or other traumatic event, the Mudical Examinations. Black White etc. 1 □Yes 2 1 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Veteran's Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Little George Roberts Nell Lucille Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mechanicsville, Maryland Jayne Marie Rivers/ Daughter 35695 Aviation Yacht Club Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 30, August 2006 4 ☐ Donation 5 ☐ Other (Specify) Queen Of Peace Cemetery Helen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, Maryland 20650 Jardiner Mchae 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) EmphysemA **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, it any, loading to in a colatic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 X No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of confijer Name and address of person who completed cause of death (Item, 23a) (Type, Print) Shret Hol 23511 HOLLYMORI 31. Date filed (Month, Day, Year) AUG 2 9 . Registrar's Signature State Registrar

Physician Medical Sections of the Wish Medical Sections of Table 1 and the Sections of Control			1 - State of Marylan Registrer	d / Depa <i>Cer</i>	artment of He tificate of D	ealth and M Death		ene <b>∠ U</b> ( g. No.	Jb	20096
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CALVERT MARON HEALTHCARE CERTS.  The property was harmonly and the property of					4b. City, Town, or L	ocation of Death		1		, , , , , , , ,
South Standard Control   South Standard Cont	Exami		Calvert Manor Healthcare Center	7.	Risina	Sun		Cecil	>	
Discretors  2 20 - 14 - 46 32	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Year)		ace (State or Foreign
Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Size   Top County   Top Count			220-14-4632 1 M 2XIF	83 Yrs.	Working Days	110013	Sept. 5,	1922		Maryland
The part is Name (First, Middle, Last)   The Marker Name (First, Middle, Last)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   Florence Creasavelle   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Summan)   The Maring Address (Street and Number Of Plant Name) (First, Middle, Macken Sum, MD 21911   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Address (Street and Number Of Plant Name)   The Maring Addr	p ,			. Toum or Lo	antion				10	2d Incide City Limits
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Feature   Temporary   Tempor	/Medical Examiner	ner	Immediate Dause (Final disease Condition resulting in death)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of the conditions).	uence of):	Carch	nema			i	Onset and Death
FFEMALE:   23c. If yes, outcome of pregnancy   1   I   I   I   Ves   2   I   Nonth   Day   Year   1   Ves   2   I   Nonth   Day   Year   1   Ves   2   I   Nonth   Day   Year   1   Ves   2   I   Nonth   Day   Year   Nonth   Day   Nonth   Day   Nonth   Day   Year   Nonth   Day   Nonth   Day   Nonth   D	of oU, cate be executed by sician and the burial-transit	dical Examir		uence of):						
25. Was case referred to medical examiner?    Yes 2   Mo	the death certification by the attending parties as	a)	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Feta	Ideath 3 ☐						,
25. Was case referred to medical examiner?    Yes 2   Mo	s tha			ulting in the u	nderlying cause give	n in Part I.		4		
25. Was case referred to medical examiner?  1   Yes 2   ENO  27. Manner of Death 1   Matural 2   Month, Day Year)  28a. Date of Injury Month, Day Year 1   Yes 2   No  28b. Time of Injury Month, Day Year 28c. Injury at Work? 28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Describe	aquire an sig		Type II Diebetes Mellits				1 ☐ Ye	s 2 No 3	3 🗌 Prob	ably 4 □Unknown
25. Was case referred to medical examiner?  1   Yes 2   ENO  27. Manner of Death 1   Matural 2   Month, Day Year)  28a. Date of Injury Month, Day Year 1   Yes 2   No  28b. Time of Injury Month, Day Year 28c. Injury at Work? 28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Describe	The law re		ASCUD				autopsy	pr ned? de	ior to coreath?	npletion of cause of
The state of the s		0				26. Place of Deat	h (Check only one	9)		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)	Phys C	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐  27. Manney of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of	28c. Injury Work	at ?				r)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)  30. Name and address of person who competed gause of death (Item 23a) (Type, Print)	LIVISION Range of a contract of the contract o	Certifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h	ome, farm, str			28f. Location (Str City or Town	reet and Number , State)	r or Rura	l Route Number,
30. Name (and address of person who completed gause of death (Item 23a) (Type, Print)  Joseph Weidner. MD 101 Colonial Way. Rising Sun. MD 21911	the Hospi in 24 hour ha Funer pletely fill	edical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.		vestigation, in my op	inion, death occur	red at the time, da	ite and place, ar	nd due to	the cause(s)
30. Name (and address of person who completed gause of death (Item 23a) (Type, Print)  Joseph Weidner, MD 101 Colonial Way, Rising Sun, MD 21911	To t To t	Σ	29b. Signature and title of certifier					d. Date signed	(Month, I	Day, Year)
Joseph Weidner, MD 101 Colonial Way, Rising Sun, MD 21911			Werther of ws		Da	044373		08 2	5/2	2006
Joseph Weidner, MD 101 Colonial Way, Rising Sun, MD 21911			30. Name and address of person who completed gause of death (Iter	п 23а) (Туре,	Print)					
31 Date filed (Month, Day, Year) 32 Benistrar's Signature			Joseph Weidner, MD 101 Colon	ial Wa	y, Rising	Sun, MD	21911			
State 31. Date filed (Mortifi, Day, Fear) 5 2006 AUG 2 5 2006	St	ate	31. Date filed (Month, Day, Year) 32. Resistrar's Signal AUG 2 5 2006	ature	hack .					

			For State Registrar	State of Maryland		artment of H		Mental Hy	giene Reg. No. 2 (	006	28597
			Decedent's Name (First, Middle, Last	)				2. Date of De	aath		3. Time of Death
	Physici /Medic		DOLORES KATHR	YN OLSON				AUGU	ST 25	, Year 2006	8:15PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	1		ity of Death	
W.			SOUTHERN MARYLA		CENT		NTON	1			ORGE'S
	Funeral Director		5. Social Security Number 6. Se 481-20-8202	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	rth a <i>y, Year)</i> 7 , 192	Coun	**
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show Finust be notified at	ច់	MARYLAND CHARLE		WALD						1 ☐ Yes 2 🛣 No
	28a-	Director	10e. Street and Number		***************************************	10f. Zip Code			10g. Citizen o	f What Coun	try?
	3a or	<u>a</u>	1202 WELLFLEET	DRIVE		2	0601		U.S.	. A .	
	ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N	o- 14. R	ace - America	
و	hours after ural', or ite		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	i	i res, specily cuba I⊡ Yes 2XDXvo	Specify:	o nican, etc.)	Spec		
15-0036	ural',	d by	3	Year or Dates:						- VV 11.	ITE
7	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural; or itema 23a or 28a-f show or other than "natural; or itema 23a or 28a-f show event, I've Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of	Business/inc	dustry
212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER			OWN	HOME	
ğ	e filed Il Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden Sumi	ame)	
<u>ब</u>		ToE	RAYMOND BERNAR	D WIEBLER			KATHRY	N THER	ESE HE	ELLIN	G
Maryland	2 a = 3		19a. Informant's Name/Relationship (T			ng Address (Street			•		
	l and fealth im 27		SANDRA K. OLSON	and the second s	4	1202 W. sition (Name of	ELLFLEE	T DR.,	WALDOE 20c. Location		
ŏ			20a. Method of Disposition 1XXX urial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cren	natory or other plac					
Baltimore,	permit. Page Department of Important: if any injury or once.		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	41110	3	CEMETE  Name and Address		-06	NASHWA	AUK,M.	INNESOTA
m	Dep Imp		10	17.1		RAYMOND	FUNERA			P.A.	
			23ai Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ent	EA PLAT er the mode of dyin	A , MARY g, such as cardia	DAND 2 or respiratory	10646 arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pieline on	50 V L					je	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	Einto	0103			100	
	Examiner	L	Sequentially list conditions,		scle	<i>rosis</i>				- 1	ears
$\overline{\mathbf{J}}$	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
Ä	xecut al-trar	xan	that initiated events resulting in death) Last	c	uence of):						
760	cate be executed physicien and the burial-transit	dlcal		d				_			
00	tificat ng phy as th	ledi	15								
ž	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	Ideath 3	Ectopic pregnancy				Date of delive Month	nry Day Year
P.O. Box	the at	Physician/Me	1 ☐ Yes 2 SNo 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)					July 100.
<u>.</u>	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the u	derlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of death?
Division of Vital Records,	uires rign	Completed by	Semlity:	Failure to	o thi	ive		10	Yes 2□No	3 🗌 Prob	ably 4 Minknown
ဂ္ဂ	s beer	olete	) (					24a. Wa		o. Were autor	psy findings available
Re	The is	mo						auto perf	ormed?	prior to cor death? 1 \( \text{Yes} \)	npletion of cause of 2 ≥ No
ita	ien: rrifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of De				
<u>&gt;</u>	hysic his ce	10	1 ☐ Yes 2 KNo		ER/Outpatien		4   Nutsing i	łome 5□Res			1)
Ĕ	ing P	lon:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury occ	urred	
Sic	death death stor: /	cat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str		Yes 2 □ No	28f. Location	(Street and Nur	Ther or Rum	I Route Number.
<u>≥</u>	after after Directory	Certification:	4 Homicide determined	building, etc. (Specify	v)	oo, .ao.o.y, ooo			wn, State)	_	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	wledge, deati	n occurred at the time	ne, date and place	e, and due to the	cause(s) and	manner as st	ated.
	the H hin 24 the F nplete	Medical	one)	and manner stated.							
	Jan S	~	29b. Signature and title of certifier  Mucleul	intell Do		29c. Licens		+5	29d. Date sign		
,			30. Name and address of person who co			Death and Late	00424	0:44.		10 76	LUCE
	10			ompleted cause of death (Item にど 及びみり,				2060		UU	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	nite	alle)	1	-	-		
	Regist	rar	SEP 0 8 200	10 Rivers	1 19						

State of Maryland / Department of Health and Mental Hygiene, 28598 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Hampton Randolph Olfus, Sr. 1745 August 18, 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly Prince George's Hospital Center Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min 1**X**M 2□ F 75 Yrs. 214-28-4317 Washington, DC Director Jan. 21, 1931 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "netural", or itema 23s or 28s-f show the Modical Examiner must be notified at 1 XYes 2 ☐ No Prince George's Glenarden Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 7928 Cawker Avenue 20706 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ↑ Never Married 2000 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. U.S. Postal Service Elementary/Secondary (0-12) College (1-4or 5+) Supervisor - Distribution 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked othen yinjury or other traumatic even Be Anna Settles George Randolph Olfus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7928 Cawker Avenue 19a. Informant's Name/Relationship (Type, Print) Gloria Emily Olfus/Wife Gleranden, 4D 20706

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 R 4 Donation 9 Other (Specify) 3 Removal from State Harmony Mem. Park 08/26/2006 Landover, MD 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Avenue, N.E. Washington, DC 20019 Enneral Sarvice Lin nsee 21. Signatur ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final 1 100 **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 Tes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No After this certification, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Mopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending 1 TYes 24 hours after death. Funerel Director: A 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🗶🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 24 To the F 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) August 21, 2006 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, Suite 113 C. Donald George, M.D. Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 2 4 2006 Registrar

			For State Registrer	• •		Depa	artment of H	ealth a		ıtal Hygier	e 2006	28599
ı	Physici		1. Decedent's Name (First, Middle	<sub>e, Last)</sub> Junior	Peer					Date of Death Month 28, 20	Year	3. Time of Death 8:07pm м
	/Medic Examin		George 4a. Facility Name (If not institution	n, give street and number;			4b. City, Town, or Cumberla	_			Ic. County of De	ath
	Funeral	3 0	Devlin Manor Nu  5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last i		If Under 1 Year Months Days	If Under a	24 Hrs. 8. [	Date of Birth (Month Bay 19	0	rthplace (State or Foreign
20	Director		215-12-2414 Usual Residence of Decedent	<b>X</b> □M 2□F	83	Yrs.			A	or 24,19	23 V	(Suntry)
	f ahow	or	10a. State 10b. County WV Mine		10c. City, To	wn or Lo Viley						10d. Inside City Limits 1 ☐ Yes X2 ☐ No
-	or 28a-	Funeral Director	10e. Street and Number				10f. Zip Code	6767		10g.	Citizen of What C	Country?
	death v	erai	P.O. Box 189	12. Was Decedent	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		gin? (Specify	Yes or No-	14. Race - An	
036	72 hours after death with the Marylend Instural; or Itams 23s or 28s-f show Vical Examinat must be collified at	by	1 ☐ Never Married 2 ☐ Mar 3 🕱 Widowed 4 ☐ Divorced	II Yas Giva	No		f Yes, specify Cubai 1 ☐ Yes 2 ☐ No	Specify:	, Puerto Rica	an, etc.)	Specifywh	
15-0	in 72 ho "natur	Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	urina most	t of working	16b.	Kind of Busines	s/Industry
212	e filed within al Hygiene. other than "	Comp	Elementary/Secondary (0-12)	College (1-4or	s+) lab	orer						I Box & Mill
land	lid be fill fental H rked oth	To Be	17. Father's Name (First, Middle, George Samu							rst, Middle, Maid Pearl Ric		
Mary	and 2 should ealth and Mer n 27 is marke		19a. Informant's Name/Relations Steven Peer	hip (Type, Print)	1	9b. Mailir HC 7	ng Address (Street a	nd Numbe	er or Rural Ro	New Cre	y or Town, State, <b>EK</b>	<sup>Zig Code)</sup> 26743
Baltimore, Maryland 21215-0036	一工事者		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5	3 □Removal from State	ceme	itery, crer	sition (Name of natory or other place Cemetery	9)	Date 9/2/		Location - City o	
Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Francia Sprvice	71/1/	M.		Name and Addison Scarpelli 108 Virgi	nia Ave	enue; C	umberland	I, MD 2150	)2
6	Physician /Medical		23a. Party Effer the disease, o shook, or heart failure. List Immediale Cause (Final disease or condition resulting in death)				er the mode of dying	g, such as	cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
*	Examiner		Sequentially list conditions,	b	. <u>.</u>	-	<i>'</i>					
$\mathcal{T}$	outed d ansit	Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events	c.	E & CONTRACULARIO	sa oty:						
,094	ite be executed sysicien and ne burial-transit	cal	resulting in death) Last		s a consequenc	ce of):						
99	ertifica ding ph	/Med	IF FEMALE:	23o H vas outcom	a of pragnancy							
.O. Box	u the death certifica by the attending ph tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year
Δ.	es that the igned by be detact	by Ph	Part II. Other significant conditi	_	but not resulting	g in the u	nderlying cause give	n in Part I.				to the cause of death?
Records,	w requir been si should	eted	Chre	porte								Probably 4. Unknown
al Rec	The lar	Completed								24a. Was an autopsy performed 1 Yes 2	prior to death?	autopsy findings available o completion of cause of
Vital	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ient 2□ER/	Outpatier	nt 3 DOA Othe	~ 1		heck only one) 5  Residence	6 □Other /Sr	necify)
n of		on: T	27. Manner of Death 1 ☐Natural 5 ☐ Pendi	28a. Date of Inj	ury 28t	o. Time o	28c. Injury Work	at	28d.	. Describe how in		cony,
Division	ten leat tor: the	ertification:		not be 28e. Place of Ir	njury - At home, etc. (Specify)	, farm, str	M 1 []	/es 2 □ !		Location (Street City or Town, St		Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical Ce	(Check only 2 Medical	ng Physician: To the bus Examiner: On the basis	of examination	dje, deati and∕or in	h ossumed at the lim vestigation, in my op	ie, data an pinion, deal	d plane, and th occurred a	due to the nausa	(n) and manner and place, and di	as stated. ue to the cause(s)
	within 2 To the	Med	29b. Signature and title of certific				29c. License	number		29d.	Date signed (Mo	nth, Day, Year)
			<b>&gt;</b> \( \dag{\partial} \)	Bollow h				1756	5	A	lept. 1,	2016
	5		30. Name and address of person	o Ir M.D		122	Vational H	ahwa	v LaVa	ale MD 2	1502	
100 miles	Sta Registi	100	31. DAnthony Bollin	8 2006	trar's Signature		have .	G- 10-100				
DH	MH 17 Rev 1/2	-	SEP U	0 2000	was so	19	1000					

ORIGINAL

	Fx				artment of Health and M			
		_	1 - State Registrar  1. Decedent's Name (First, Middle, Last)	Cei	tilicate of Death	Reg. N	°2006	28600
	Physici		LEE EDWARD PA	IM			ay Year	1433 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	7) 4	4b. City, Town, or Location of Death		tc. County of Death	1100
	LXamiii		Wostlington County has	oital	Hegerstown	V	NOSHINITO	$\mathcal{L}$
	Funeral		5. Social Security Number 6. Sex 7.	ge (In yrs. last birthday)	If Under I Year   If Under 24 Hrs.	8. Date of Birth	9 Birtho	lace (State or Foreign try)
	Director		170-34-8341 ¹₺M '2□ F	65 Yrs.		(Month, Day, Yea April 23,		nsylvania
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		11	Od. Inside City Limits
	Mary -fehr	tor	Maryland Washington		Smithsburg			1 ☐ Yes Ž☐ No
•	r 28a	Directo	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Coun	try?
	th wit	a D	11403 Crystal Falls Drive		21783		U.S.A.	
	•me	Funerai	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 27 ☐ Married 1 ☐ Yes 22 ☐ If Yes, Give Year or Dates	] No	1 ☐ Yes 2 No Specify:		Specify:	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28e-f ehow aumatic event, the Madical Examinar must be notified at	ed b	15. Decedent's Education		dent's Usual Occupation	16b	Whi:	
5	n na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-40	(Give	kind of work done during most of working NOT use retired)	ng los.	Tally of Dashlossanic	Justiy
212	d with giene er the	E O	12 College (1-40	54)	Butcher		Grocer	1
g	be filed ital Hygid of other event.	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	en Sumame)	
<u>X</u> a	should to the marked umatic	2	Leroy E. Palm		Anna	Labash	·	
Maryland	2 sh and 1s m	1	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rura			- 1
	s 1 and 2 should if Health and Men Item 27 is marke other traumatic.	1	Mary Louise Palm (Wife) 20a Method of Disposition	20b. Place of Dispo	Crystal Falls Dri		bur , Maru Location - City or To	
ခွ	Pages nent of ont: If It		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State	8	natory or other place) Septe	mber 2	•	
altimore,	permit. Pages Department of Importent: If I eny Injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		rg Crematory 2			Maryland
B	Dep Production		Jack Daris		525 Bradbury Ave.		vis Funera	
			23a. Part1. Enter the disease, or complications that causshock, or heart failure. List only one cause on each	ed the death. Do not ent			g / Hargran	Approximate Interval Between
	Physician			DOMONAS	Sensis			Onset and Death
	/Medical		resulting in death)	s a consequence of):	-0350			
	Examiner		Sequentially list conditions. b. + Sequentially list conditions.	COMONOS	Phreimonia			
1	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):	\			
٧_	sicien and burial-transit	Examiner	that initiated events c.	s a consequence of):				
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89								
Box	death certifical e attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		Ectopic pregnancy		23d. Date of delive	•
	0 0 0	Physician/Med	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  9 ☐ Unknown		Other (specify)		Month	Day Year
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ဂ္ဂ	w require been sig should b	lete	Acute Penal Falle	0		24a. Was an	24b. Were autor	osy findings available
æ	The la	Completed	PIOT S. A.A. HOST	Felian		autopsy performed2	prior to con	npletion of cause of
ā	iclan: The law certificate has t rector, page 2 s	a	25. Was case referred to medical	talupp	26. Place of Death	(Check only one)	lo 1 ☐ Yes	208 NO
Division of Vital	Physica this ce	To B	examiner? 1 Yes 2 No Hospital: Inpa	tient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hor	ne 5 Residence	6 ☐Other (Specify	)
ت 0	el or Attending Ph s efter death. Il Director; After th ed in by the funeral		27. Manner of leath 28a. ate of In (Month, D	jury 28b. Time of lay Year) Injury	Work?	28d. Describe how in	jury occurred	
20	tend death tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
$\leq$	5 E E	Certification:	determined 206. Flace of t	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street a City or Town, Sta		Houte Number,
	Hospitel 24 hours e Funeral I tely filled		29a. Certifier Certifying Physician: To the bes	at of my knowledge, death	occurred at the time, date and place, a	and due to the cause	(s) and manner as st	ated.
	To the Hospitel within 24 hours e To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	of examination and/or in-	vestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to	the cause(s)
	To the vithin 2 To the complet	Ž	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, L	Day, Year)
ı			MIS. Bonen AD		0205307/	09	101/06	
	12		30. Name and address of person who completed cause of		1 11 11	7	IN alma	R
	1 0		31. Date filed (Month, Day, Year)  32. Belies	trans Signature	114 1650 101 / HAS	Jessown, 1	MD 21746	
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			OF! O COOL STREET	- //				

06-06145

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ada Price 1- For State Certificate of Death Reg. No egistrar Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day August 17, 2006 1835 hrs Ada Yvonne Price Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) Prince George's Riverdale 4709 East/ West Hwy 8. Date of Birth (MM/DDAXXYY) 9. Birthplace (State or Foreign Ohio If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Davs Hours Directo Country) 76 323-24-5106 February M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County N V 10a, State 1 X Yes 2 No or 28a-f show DCWashington with the Maryland notified at once Director 10f Zip Code 10g. Citizen of What Country? 10e Street and Number 2300 Good Hope RD S.E. #125 IISA 20020 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death v Armed Forces' 2 X Married 1 Never Married Yes **Black** Specify after Divorced If Yes, Give Year 1 Yes 2 X No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 2yrs Executive Officer Private Com 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) unk Albertus Conn Yvonne Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2300 Good Hope Rd S.E. #125, Washington, DC 20020 Grover Price/ Husband 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Riverdale Crematory 8/21/2006 Riverdale, Maryland Donation 5 Other Specify 22. Name and Address of Facility Johnson and Jenkins F.H. Sign Ture of Funeral Service Lice 716 Kennedy St., NW Washington, DC caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the di or complications the Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Deep Venous Thrombosis Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner c. Right Leg Fracture (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medica tending physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an been autopsy prior to completion of cause of performed? death? 1 🗸 Yes page ✓ Yes 2 No 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene DOA Inpatient ER/Outpatient 3 After this 1 V Yes ဥ 28a Date of Injury (Month, Day, Year) FOUND: 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification: Subject fell **FOUND** Natural 1 Yes 2 ✓ No 5 Pending death the Funeral Director: notestely filled in by the Aug 17, 2006 1830 hrs 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 4709 East/ West Hwy., Riverdale, Md. (Specify) Nursing Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number August 18, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 5

			For State Registrar	State of I	Maryland		artment o			Mental Hy	giene Reg. N2	006	28602
	Physici	an	Decedent's Name (First, Middle,     Adaline	Last)		Padget	+			2. Date of De Month	Day	Year	
	/Medic Examin	_	4a. Facility Name (If not institution,	give street and number	9r)	rauget	4b. City, Tow	m, or Loca	tion ol Deat	August	_	2006 county of De	11:35A M
8	Examili	lei	Civista Medical		,			Plata				harles	
	Funeral Director		5. Social Security Number 577–16–0911	5. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. la. 94	st birthday) Yrs.	Il Under 1 You Months Da	ear If U	nder 24 Hrs urs Min.	8. Date of Bird 12/08/1	h χ. Υθα <i>r)</i> 911	9. B Sc	inthplace (State or Foreign Country) outh Carolina
4	ס		Usual Residence of Decedent		140.00								
	Aarylar I show	ō	Maryland Prince	George's		Town or Lo t. Wash							10d. Inside City Limits 1 ☐ Yes 2 No
	728a-	Director	10e. Street and Number	9018C 5	1	L. Wasii	10f. Zip Cod	de			10g. Citize	en ol What (	Α
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mentall Hygiene. Department of Heatin and Mentall Hygiene.  any Injury or other traumatic event, It a Medical Exact it at most be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ➡ Widowed 4 □ Divorced	12. Was Decede Armed Force d 1 Yes 27 If Yes, Give Year or Date	s? <b>X</b> No		Was Decedent I Yes, specify ( I □ Yes 😥		ic Origin? (S exican, Puer ecify:	pecify Yes or No o Rican, etc.)		Black, Wh	nencan Indian, nite, etc. White
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<u><u>E</u></u>	Page ment cant; if ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		110	s Crema	atory			5/2006	Edoew	ater.	Maryland
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			23a. Part 1. Enter the disease, or o shock, or heart laiture. List of	_				dying, suc	ch as cardia	or respiratory a	rest,		Approximate Interval Between Onset and Death
1 3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	as a conseque		4						2 DAYS
	Examiner		Comments the first considérance	b	as a conseque	orice ory.							
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ion	ath. r: Afte	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Intury		Work? 1 ☐ Yes	2 🗆 No				
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	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical E	Physician: To the be xaminer: On the basi	s of examination	riedge, death on and/or in:	occurred at the	ne time, da my opinion	ite and place	, and due to the irred at the time,	cause(s) a date and p	nd manner a	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	one)  29b. Signature and title of sertifier	and manner	stated.		29c. Lie	cense num	ber		29d. Date	signed (Moi	nth, Day, Year)
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2	(7)		30. Name and address of person w								6	)	1
			Ashvinkumar J.  31. Date filed (Month, Day, Year)	Patel, MD	102 Pa	aul Me	llon C	ourt	Ste.	102 Wald	orf,	Mary1	and 20602
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		•	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth and Death		Re	g. No. Z	006	28	3603
			1. Decedent's Name (First, Middle, La	st)						2. 0	ate of Death	Dav	Year	3. Time	of Death
	Physicia /Medic	_	Doris 1	Maxine	PIKE					Au	Month gust 2	6, 20	06	200	AM
	Examin		4a. Facility Name (If not institution, giv	e street and nur	mber)		4b. City, T	own, or	Location of D	Death			ty of Death		
			524 Jefferson St	reet					town			Was	hingto		
	Funeral		5. Social Security Number 6. S			. last birthday)	If Under 1 Months	Year Days	If Under 24 I Hours N	Hrs. 8. D	ate of Birth	Year)			or Foreign
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Baltimore,	permit. Pages 1 and 2 should be Department of Heabilb and Menta Important: If Item 27 is marked eny injury or other treumatic e- page.		20a. Method of Disposition			Place of Dispo	sition (Nam	e of her plac	9)	Date		20c. Location	- City or To	wn, State	
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	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	×	29b. Signature and title of certifier	2 324	36.0		29c	. Licens	e number		2	9d. Date sign	ned (Month,	Day, Year	r)
			Muchael	ne	found	MO	1	00	1/66	7		8.7	8.0	16	
			30. Name and address of person	completed cau	ise of death (It	em 23a) (Type	Print)				Green and a	, , ,		15	
91	1-2		29b. Signature and title of certifier  30. Name and address of person  Michael M  31. Date filed (Month, Day, Year)	Corn	ack	11110	Melia	cel	Comp	101 1	Rd.	Huse	rutou	vn.	MO
1	Sta	ate	31. Date filed (Month, Day, Year)	32. 1	Ragistrar's Sig	nature	lacks	-							
A.	Regist	rar	AUC 28	2006   1	Bellia	1. P									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $200\, 6$

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 02,2006 5:05 P M Larry Eugene Reuter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 15006 Rice Road Hancock | Hall Cock | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | April 28,1944 | District of Columbia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Yrs. 62 Director 223-56-8141 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Washington Hancock 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21750 15006 Rice Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hauling/Delivery 12 Truck Driver or other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permii. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 Is marked oth any jiury or other traumatic evant 2008. Be Fred C. Reuter Mary Flack 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys J. Reuter/Wife 15006 Rice Road Hancock, MD 21750 Road Disposition (Name of Date 20c. Lo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Crematory 09/05/06 Smithsburg, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 at caused, e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each re 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 🔁 N 25. Was case referred to médical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Matural s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, Print) address of person who completed ASSITE 11111 mode 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2006

			For		State of Ma					ental Hyg	iene			
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	r Rem	Funeral	Marital Status     Never Married		Armed Forces?  1  Yes 2 N  If Yes, Give		If Yes, sp	ecify Cuban, Mex	rican, Puerto	Rican, etc.)	ВІ	ack, White,		
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ָה ק	natu disal	Completed	15. (Specify o	Decedent's Educ only highest grade	cation completed)	16a. De	cedent's Us	ual Occupation ork done during r use retired)	most of worki	ng	16b. Kind of	Business/Ind	dustry	
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Mar	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene.  Department: If them 27 is marked other than "natural; or Name 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at ance.		19a. Informant's Name Dorothy F		wife	19b. Ma <b>1</b> 4	ailing Addre	ss (Street and Nu I. Bel Air	Drive	Al Route Number Cumb	c City or Tow Derland	n, State, Zip MI	21502	
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ďŠ,	The law requires that the ate has been signed by the page 2 should be deteched.		C000	win		ساد الم				10804	es 2□No	3 ☐ Prob	pably 4 □Unknown	
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	20		30 Name and address	of person who co	ompleted cause of d				0 1	1	1 1	1	4, 2006 1 21502	
			Mr. Gregg 31. Date filed (Monny	Doy Year)	SON Sistr	912 Set ar's Signature	onk	rive,	Lumb	erland	, Mar	yland	1 21502	_
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State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:45P M 13, AUGUST 2006 DANIEL RUFFIN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY SILVER SPRING HEALTH CENTER MANOR CARE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 xM 2 □ F Yrs. Director 1932WASHINGTON, 74 577-44-5169 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show traumatic evant, the Madical Examiner must be nutified at 1 Yes 2 □ No MD PRINCE GEORGE'S LANDOVER HILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a UNITED STATES 20784 7014 BARTON RD Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1√D Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 l. Department of theatth and Mental Hygiene. important: If Item 27 is marked other than "naturany injury or other traumatic acceptance." 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) PRINTER GOVERMENT 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ALICE HINES LOUIS RUFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL RUFFIN JR/SON 54 SOUTH PAULA ST., LAUREL, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 □Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-25-06 CHELTENHAM, MD VETERANS CEM. 21. Signature of Funeral Service L 22. Name and Address of Facility CAPITOL MORTUARY Show 1425 MARYLAND AVE., N.E. WASH., D.C.20004 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. List fmmediate Cause (Final CEREBRAL VASCULAR ACCIDENT Physician disease or condition resulting in death) /Medical Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death the 9 Unknown 9 X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩ No 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No ihis 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a e Funeral [ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certific 29c. License number D0057042 8-23-06 nd address of person who completed cause of death flam 23a) (Tx WON KAISER LA 30. Name a 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

AUG 2 4 2006

06-06482 Susan Ricketts

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	,	Certifica	te ot	Death			,,,	Re	g. No.	200	16	2860
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Baltimore, permit. Pages I an Department of Her Important: If ite	ı	21. Signature of Funeral Service Licen	see D O O		<sup>22</sup> M	ARSHAI	dress S	Facility	ERAL I	HOME	OF MA	RYLANI	),IN	С.
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Division of Vital Records, tal or Attending Physician: The law requinrs after death.  "In Director: After this certificate has been sited in by the funeral director, page 2 should be an every page 2 should be a proving the funeral director.	ion	1 Natural 5 Pending	(Month, Day, Yea	ar)	,		1 Ye	es 2 x	No 1	nk				
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Hos 24 h Fur tely		29a. Certifier 1 Certifying Physic	ian: To the best of my	knowledge, dea	ath occur	red at the ti	me, dat	e and plac	ce, and due	to the caus	se(s) and m	nanner as sta	erted	-(-)
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96		30 Name and address of person who Laron Locke MD. Assis	completed cause of de tant Medical Exa		1 Penn	Street, I	Baltim	ore, ME	21201					
	tate		32. Registrar			/								
Regis			leve &	Annal										

#### 06-06558

Richard Ivan Reed

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 2319 hrs September 1, 2006 Medical Examine Richard Ivan Reed 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Perryville Cecil 147 Starboard Court 9 Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreigr Pennsylvania Country) Months Davs Hours Director Dec. 23, 1947 074-40-1575 58 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County SILV 1 X Yes 2 No Perryville 28a-f shov Cecil Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once. hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21903 U.S.A. 147 Starboard Court 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, 8lack, Funeral 11 Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 1X Yes White If Yes, Give Year 1964-92 1 Yes 2 X No specify: Specify. 4 X Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Jacobs Sverdrup ages I and 2 should be filed within 72 ho nt of Health and Mental Hygiene t: If item 27 is marked other than "na other traumatic event, the Medical Ex. Elementary/Secondary (0-12) College (1-4 or 5+ Tullahome, Tennessee Baltimore, MD 21215-0036 Engineering Tech III Twelve Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willis Ivan Reed June Stiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brian J. Reed (son) 18 Mansion Drive, North East, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) permit. Pages 1 Department of H Important: If i or other 1 X Burial 2 Cremation 3 Removal from State North East Cemetery 09/08/06 North East, Maryland Donation 5 Other Specify: Signature of Funeral Servi L L nsee 22 Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical XUNPENDED fing physician a AMENDED item#23a,27,perME,g859,9/13/06 TI Box 68760 23d. Date of delivery IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Day Year Month Live birth Fetal death past 12 months? use Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown y the attached f Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? page 2 Yes 2 No 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25 Was case referred to medical Be Hospital: 1 Other 4 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 this 1 V Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 X Natural Yes 2 No Division 5 Pending death. Director: the Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be within 24 hours a 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E September 2, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Jack Titus MD

31. Date filed (Months Day, Year)

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

2006

32. Redistrar's Signature

		•	1 - For State Registrar	State of Maryl	and /			nt of He te of D		d Mei		giene Reg. No	71111	6	286	509
	Physici	an	Decedent's Name (First, Middle, Last)     Juana E.	Romero	De	He	rnan	dez			Date of De Month	Day		ar	3. Time of	Death a. M
	/Medic	al	4a. Facility Name (If not institution, give s						Location of De		lugust		2006 County of E	eath	5:00	
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	and *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, To	wn or Lo	cation							10	d. Inside C	ity Limits
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lan	and and is mu		19a. Informant's Name/Relationship (Typ	oe, Print)	11	9b. Mailir	ng Addres	s (Street a	ind Number or	Rural F	Poute Numb	er, City o	or Town, Sta	te, Zip (	Code)	
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ij	교투관금 .		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		ate of			meter		006		Silv	er Sp	ring	J, Mai	cyland
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			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the	death. D				sity B g, such as card				r spr		Approximation Ap	te
	Physician		Immediate Cause (Final	J											Onset and	
	/Medical		disease or condition resulting in death)	Hepatic C Due to (or as a cor												
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387	ate Physical	Physician/Medicai														
9 x	eath certific attending p for use as	/We	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pr									23d. Date of	deliver	ry	
Box	death a atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time			]Ectopic   ] Other <i>(</i> s	pecify)				i de	Month	1	Day	Year
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S, P	es tha igned be del	by P	Part II. Other significant conditions con	tributing to death but no	t resulting	g in the u	nderlying	cause give	on in Part I.				use contribu			
ord	w require been si should l									_	10	Yes 2	□No 3[	] Proba	ably 4X	Unknown
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á	s after a Direction by	Certification:	4  Homicide	building, etc. (S	pecity)						City or To	wn, State	θ)			
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	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Da	ite signed (A	Aonth, E	Day, Year)	
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			30. Name and address of person who co	empleted cause of death	(Item 23	a) (Type,										
			Cynthia Williams					Mill	Road,	Roc	kvill	e, M	ID 208	55		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	Registrar's S	Signature	Con	and the									

		•	For State Registrar		State	of Mar	yland	l / Depa <i>Cer</i>	rtmer <i>tifica</i> :	nt of H te of L	ealth D <i>eath</i>	and M	lental Hy	/giene Reg. No	2006	. 2	2861	0
			1. Decedent's Name (First, Mid										2. Date of D	eath		3	<ol><li>Time of Deat</li></ol>	h
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an	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or Items 23e or 28e-f ahow arted other than "natural", or Items 20e or 28e-f ahow atte event, the Mydical Exx infratriust be notified at	To Be	Theodore Cu	ıthbe	rt i	Kettn	ner					Не	len	Cle	ementso	n		
Maryland 21215-0036	shound M		19a. Informant's Name/Relation					19b. Mailir	ng Addres	s (Street	and Num	ber or Rur	al Route Num	ber, City	or Town, State,	Zip Co	ode)	
Ž	aith a 27 ls		Dorinda Demer	nt, d	au ht	er		5375	Buen	a Vis	sta I	Rd.,	Prince	Fre	derick,	MD	20678	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-f ahow any injury or other traumatic event, the Marical Extrainer must be notified at the.	-	21. Signature of Funeral Servi	Licens	1	_		22	2. Name a	ind Addre	ss of Fac	ility Ra	usch F	ıner	al Home	, P	.A.	
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Division of Vital Records,	il or Attend after death I Director: /	Certification:	4 Homicide det	benimed	bui	ilding, etc.	(Specify	()	1001, 1401	,, oo			City or T	own, Sta	te)			
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	_1	For State Registrar		Maryland /		nent of H cate of I		and M	F	1eg. No 20	06	2861
Physician /Medica Examinei	1 1	Decedent's Name (First, Middle     Facility Name (If not institution     Doctors C	Leon			City, Town, or	Location of		2. Date of Dea	Day 4c. Coun	Year 2006 ty of Death <b>Prince</b> (	3. Time of Death //: 03A
Funeral Director		5. Social Security Number 219-05-1973		Age (In yrs. last b		Under 1 Year onfhs Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Feb 1	h /, Year) 5, 1919	9. Birth Cou	place (State or Foreig ntry) <b>Maryland</b>
death with the Maryland me 23a or 28e-f show count be notified at		Usual Residence of Decedent 10a. State 10b. County MD	Calvert	10c. City, Tov	vn or Location	on	St. Lec	nard				10d. fnside City Limit
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nd 2 should th and Men 27 la marke r treumatic		19a. Informant's Name/Relations Ruth Reynolds/wife	nip (Type, Print)		•	,			al Route Numbe I, MD 2068		n, State, Zi	p Code)
oermit. Pages 1 an Department of Heal mportant: If Itam 2 any injury or other 2058.		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		ate cemet		n (Name of ry or other place urch Cemet			Date //26/06	20c. Location		own, State ard, MD
permit. Departr Importa any inju		21. Signature of Funeral Service	P. Lewel	ee	22. Nar	me and Addres Sewell F 1451 Da			ad Prince I	Frederick,	MD 20	678
nte be nysicie ne bur	icai Ex	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or Due to (or d.	r as a consequence r as a consequence r as a consequence r as a consequence r A F T T	of): of): of): of):	45	vitt	a	Bsco	SS		
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The law ate has be page 2 s	Completed	Acute	rena	l A Can	cer	re					o. Were aut prior to co death? 1 \( \text{Yes}	opsy findings availab ompletion of cause of 2 \( \subseteq \text{No} \)
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Hospitel of the hours at Funeral Diely filled it		(Check only 2 Medical	g Physician: To the b Examiner: On the bas	is of examination a	ge, death occ	curred at the tir	ne, date an	d place,	and due to the	cause(s) and r	manner as	stated, to the cause(s)
To the Hospitel or Atterviewithin 24 hours after de To the Funeral Directo completely filled in by the	Medical	29b. Signature modifie of certified	and manne	or stated.		29c. Licens	e number			29d. Days sign	ned (Month	. Day, Year)
10+1		30. Name and address of person	who completed cause  O VOIC HU  32. Rev	of death (Item 23a	(Type, Print				Lan	8/18/ ham,	MD	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Philip Francis Reichmeider 05 august 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hagerstown Washington County Hospital Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2□ F Yrs. Director 085-09-2896 97 August 8 1909 New York Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Worle "naturel", or iteme 23a or 28a-f ehov adical Examiner must be notified at 1 ☐ Yes 2√∑ No Directo Florida Palm Beach West Palm Beach 10e. Street and Number 10g. Citizen of What Country? 732 McIntosh Street U.S.A. 14. Race - American Indian, by Funeral 33405 permit. Peges 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: If tem 27 is marked other them? any injury or other treum. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ Felix Reifschneider Henrietta Granley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9220 Holy Hill Farm Rd. Charlotte N. Carolina 28277 Peter Reichmeider 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Aug 31 2006 Long Island New York Pinelawn Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Ligenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) READYCARDIA **Physician** /Medical Due to (or as a consequence of) Examiner HYPOTENSION Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine DIAL INFARCTION transit or Attending Physician: The law requires that the death certificate be executed end physicien er Division of Vital Records, P.O. Box 68760, DISTANT Completed by Physician/Medical use as the attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed l d be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BNA 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed/ certificate 2□ No 2 1 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No neral Director: A investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter To the Funeral Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) JH-20 25 East 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2006 Registrar

			For State Registrar	State of	Maryland		rtment of		and Me	ental Hyg	iene <sub>og. No</sub> 2 (	006	28	613
	Physicia		Decedent's Name (First, Middle	Doris	Stouf	fer			2	2. Date of Dea Month		Year		of Death 3:51 <sup>M</sup> A
	/Medic Examin		4a. Facility Name (If not institution Saint Jo	, give street and numb seph Med:	ical C	enter	4b. City, Town,	or Location o		son	4c. Cou		alti	
Au .	Funeral Director		5. Social Security Number 219-14-8176	6. Sex 7. 1 ☐ M 2 점 F	. Age (In yrs. Ia	ast birthday) Yrs.	Months Day		Min. J	Date of Birth (Month, Day) Suly 29	1924	Co	nplace (Stat untry) ary1an	
	Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County  Penna. Fra	nklin		Town or Lo								City Limits
	with the	Directo	10e. Street and Number	haran Dal			10f. Zip Code			1	10g. Citizen		untry?	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Maddeal Examinar count be matified at	by Funeral	14918 Mercers  11. Marital Status  1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2	es? ☑No	- 1	Nas Decedent of I Yes, specify Cu	Hispanic Original Iban, Mexican	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)				
Maryland 21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0·12)	t's Education st grade completed)  College (1-4	4or 5+)	(Give	lent's Usual Occ kind of work dor DO NOT use reti	ne during most red)	t of working	7		f Business/	Industry	e
land 2	al Hygi other	To Be Co	17. Father's Name (First, Middle, Law	-	land			18. Mothe		First, Middle,			-	
Mary	12 shou h and M 7 is mar traumat		19a. Informant's Name/Relations Lawrence E. S		shand	7	g Address <i>(Stre</i> 18 Merce							
Baltimore, I	permit. Pages 1 and 2 should b Department of Health and Menit Important: if item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from S	20b. P	lace of Dispo emetery, crei oadford	sition (Name of natory or other p ling Chu	rch	Da 9/2/0	te )6	20c. Locati Hage:	on - City or	Town, State	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service	Zimmen	-0-	2 4	Name and Add Lmmerman S. Car					Inc. Pa. 1	7225	
	Pnysician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aCf	ARDIOG	ENIC		ying, such as	cardiac or	respiratory ari	rest,		Approxir Interval Onset ar	nate Between nd Death DAYS
	/Medical Examiner				r as a consequ [ TRAL		ORTIC	VALVE	REP	LACEM	ENTS		3	DAYS
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٥,	cate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	Due to (o	r as a consequ	uence of):	RDIAL I							WEEKS
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σ.	es that igned b	þ	Part II. Other significant conditi		_	ulting in the u	nderlying cause	given in Part I		23e. Did to	obacco use			of death?
Vital Records,	The law ate has b page 2 sl	Completed								24a. Was autop perfo 1 Yes		4b. Were au prior to death?	completion	gs available of cause of
Vita	tician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:		FB/Outratio	nt 3 DOA	Other:		(Check only o		Other (Spe	northy)	
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Division	P afte	Certification:	3 Suicide 6 Could 4 Homicide deterr	mined 288 Place	of Injury - At hog, etc. (Specif	ome, farm, st	reet, factory, office	Ce Ce	2	8f. Location (S City or Tox		umber or R	ural Route f	lumber.
	Hos Pun Bely	edicai	29a. Certifier 12 Certifyi (Check only one) Medical	ng Physician: To the Examiner: On the ba \(\hat{\Omega}\) and \(\omega_{\Omega}\)nn	sis of examina	wledge, dear tion and/or in	h occurred at the evestigation, in m	e time, date ar ny opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) an date and pla	d manner a ice, and du	s stated. a to the caus	se(s)
	To the Hos within 24 hr To the Fur completely	₩	29b. Signature and the of certific	er /	M	, W	29c. Lic	D: 354	53	4	29d. Date s	igned (Moni	th, Day, Yea	r)
	6		30. Name and address of person					- Mal + Mar				1		
	St Regist	ate rar	LINDA BAR 31. Date filed (Month, Day, Year SEP 0 8	32.	egistrar's Signa	ture	ORIVE T	UUSUN		YLAND	_ 212(	14		

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No 2 0 0 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** 30, 5:57PM SANDRA LEIGH SCIRANKO AUGUST 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9640 TERRI DRIVE LΑ PLATA CHARLES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 □XF 51 AUG.19,1955 FLORIDA Director 217-68-7837 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑No MARYLAND CHARLES LA PLATA Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20646 Completed by Funeral 9640 TERRI DRIVE Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X XVo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) WASHINGTON POST NEWSPAPER 12 SALES MANAGER 7 Is marked otha traumatic evant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROY BROWN LOVERIN, III GLADYS LOUISE LEE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health am 27 I 9640 TERRI DRIVE, LA PLATA, MARYLAND 20646 ROBERT A. SCIRANKO-SPOUSE itam 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or of 1 ☐ Burial 2XX remation 3 ☐ Removal from State METROPOLITIAN CREMATORY 9-1-06 ALEXANDRIA, VA \* 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility 21. Signature of Funeral Service Licenses RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovanian Motastatic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tay later underlying cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown á signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐ Yes 2 M No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1(Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) d manner stated. tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and talle of certifier 1000 52917 ans 30. Name and iddress of person who completed cause of death Item 23a) (Type, Print) 102 Centennial St. # 102, LaPlata  $M.\Delta$ 31. Date filed (Month, Day, Year) 32. Pasistrar's Signature State SEP 0 8 2006 Registrar

			1 - For Amend #5 Per FH G865	tate of Marylar	nd / Depa <i>Cei</i>	artment of H tificate of	lealth and I Death	Mental Hygi	ene g. No. 200 {	28615
	Physici		Decedent's Name (First, Middle, Last)     Chest	er Whitmore	Seilh	amer		2. Date of Death Month HUGUST	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stree Washington County			4b. City, Town, o	or Location of Death		4c. County of Dea	ith
	Funeral Director		5 <b>217</b> al Security Number 6. Sex 1⊠ M	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 23	Q Bi	thplace (State or Foreign country)
	D.	or	Usual Residence of Decedent  10a. State 10b. County  MD. Washington		ty, Town or Lo Hager					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	vith the l	Direct	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
36	be filed within 72 hours after death with the Maryland tial Hygiene. In the matural, or Itams 23a or 28a-f ahow avent, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in L Armed Forces? 1 J Yes 2 M No If Yes, Give I Year or Dates:		217 Was Decedent of he f Yes, specify Cub	40 Hispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	U.S.A.  14. Race - Am Black, Wh  Specify: V	
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8760,	death certificate be executed  Nedical  Nedical  Parameter of the purial transit  Afor use as the burial transit	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call insease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consec	AUCL guence of):	velim	. /	J dislo-		Approximate Interval Between Onse and Look
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of Vital	Physician: 1 r this certificet ral director, p	To Be	25. Was case re rred to medical examiner?  1 Yes 2 Pro Hosp	ital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott	200	th (Check only one ome 5 ☐ Resider	nce 6 Other (Spe	ocify)
Division o	tending leath. tor: After the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	8a. Date of Injury (Month, Day Year) 8e. Place of Injury - At h	28b. Time of Injury		ny at rk? ∣Yes 2 □ No		eet and Number or F	ural Route Number,
ā	To the Hospital or At within 24 hours after of To the Funsral Diract completely filled in by		29a. Certifier 1 Certifying Physicie	building, etc. (Speci	owledge, death	occurred at the ti	me, date and place	City or Town,	use(s) and manner a	s stated.
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examiner:	On the basis of examinand manner stated.	ation and/or inv	/estigation, in my o	opinion, death occu	rred at the time, da	d. Date signed (Mon	e to the cause(s)
			30. Name and address of person who compl	HV MD eted cause of death (Ite	n 23a) (T <b>y</b> noe,	U36	3655	1	Ugust 2	6,06/2006
	Sta	to.	324 EUST ANT 31. Date filed (Month, Day, Year)	32. Registrar's Sign	nelf.	Juile 2	ee tinge	Utraw,	MO 217	yo
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Albert H, 2:32 P<sup>M</sup> 23 2006 Stitt Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland hospital Center Clinton If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Days Months Hours 74 110-24-1486 Director 27, 1931 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits rthan "natural", or Itams 23e or 28e-f show the Medical Examiner must be notified at MD Prince Georges Fort Washington 1 Yes XXNo **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20744 1513 Aragona Boulevard 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1951 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married r ves, Give 1951 Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Conductor Transportation s 1 and 2 should be fited w Health and Mental Hygier tem 27 Is markad other ti traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elma Thomas John Stitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Stitt - wife 1513 Aragona Boulevard, Fort Washington, MD 20744 Health a item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vet. Cem 8-29-06 Cheltenham, MD 21. Signal of e of Funeral Service Licer 22. Name and Address of Facility Bell and Johnson Funeral Home PA 6503 Old Branch Ave. Temple Hills, MD 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Pulmonary Embolism days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Deep Venous Thrombosis days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed Prostate Cancer 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2**X** No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury death. 1 Tes 2 No investigation after death Diractor: / J in by the f 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide a 24 hou.∟ the Funaral Dirr Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 24,2006 D32800 aduly (3) 30. Name and address of person who completes cause of death (Item 23a) (Type, Print) H. Herbert Washington

Registrar DHMH 17 Rev 1/2001

State

11701 Livingston Road,

AUG 2 4 2006

31. Date filed (Month, Day, Year)

Suite 205, Fort Washington, MD 20744

		1 - For State Registrer	State of Mar	yland / Depa <i>Cer</i>	rtment <i>tificate</i>	of Health and I of Death	Mental Hyg	iene <sub>g. No.</sub> 200	06 28617
		1. Decedent's Name (First, Middle, Last)	)			-	2. Date of Deat Month		3. Time of Death ear
Physic /Med		Alda Sturgill					Aug. 22		8:57 p M
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Location of Death	1	4c. County of	_
		4206 74th Avenue				ttsville			George's
Funera	al	5. Social Security Number 6. Sec	x 7. Age ( ] M 2 🔀 F	in yrs. last birthday)	If Under 1 Months		(Month, Day,	Year) 9	Birthplace (State or Foreign Country)
Directo	r	5//-56-1440	] M 280 F	76 Yrs.			12/2/19	29	Italy
pur *		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
anyla	ō		ide1	Lothian					11☑Yes 2☐No
the N	ect	10e. Street and Number			10f. Zip (	Code	1	0g. Citizen of Wha	at Country?
with	Funeral Director	307 Seven Oaks La	ine			20711		USA	
eath	era	11. Marital Status	12. Was Decedent Ev	er in U.S. 13. \		ent of Hispanic Origin? (S fy Cuban, Mexican, Puerl	pecify Yes or No-	14. Race -	American Indian,
ter d	l P	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No				o Rican, etc.)		White, etc.
hours at	2		If Yes, Give Year or Dates:		1 □ Yes 2	X No Specify:		Specify:	White
2 hou	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual	Occupation	rkina	16b. Kind of Busin	ness/Industry
d within 72 giene. or than 'ne the Madic	De	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use	e retired)	King		- 1
d will	Completed	12		Re	tail			Private	
T SHEET	Be						ne (First, Middle,	Maiden Sumame)	
y idental build be file Mental Hy mrked oth	10	Giovanni Trampus				Alma	•		
Mary		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address	(Street and Number or Re	ıral Route Numbei	r, City or Town, St	ate, Zip Code)
and 2 valth a 27 l		Mary L. Greco - D	aughter			Ave., Hyatt			
of Head		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Damayal from State	20b. Place of Dispo cemetery, cres	osition (Nam matory or ot	ne of her place)		20c. Location - Ci	•
Page Page Int: If	1	4 □ Donation 5 □ Other (Specify)		Arlington	Natio	alCemetery 9/1	.3/2006	Arlingto	n, Virginia
DEBILLINOTE, INIGITY IGILIC Z.I.Z.13-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at	- Buce	21. Signiture of Funeral Service Licens	Thu			d Address of Facility Ga altimore Ave			-
		23a./Parti. Enter the disease, or comp	lications hat caused t	ne death. Do not ent					Approximate Interval Between
		shock, or heart failure. List only o	9.78	:atic canc					Onset and Death
Physicia /Medica	_	disease or condition resulting in death)	a/	consequence of):	eı				
Examine	-		_ `	cancer					
	a la	Sequentially list conditions, if any, leading to immediate	b	consequence of):					
uted ansit	2	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
exec n an ial-tr	Fxaminer	resulting in death) Last	Due to (or as a	consequence of):					
HECOTGS, P.O. BOX 58/6U,  The law requires that the death certificate be executed ate has been signed by the attending physicien and bege 2 should be detached for use es the burial-transit	leal		d						
ox ifficat g ph)	1								
BOX 6 eath certific attending p	by Physician/Ma	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o 1 ☐ Live birth 2		∃Ectopic pr	egnancy		23d. Date	,
deatte	100	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at ti		Other (sp.			Month	h Day Year
IS, F.C. I	2	9 🗆 Unknown							
s that med b	٥	Part II. Other significent conditions co	ontributing to death but	not resulting in the u	inderlying c	ause given in Part I.			oute to the cause of death?
VITAI HECOFGS, iician: The law requires t certificete has been signe rector, pege 2 should be r							1 🗆 Y	′es 2 <u>1</u> k2ìNo 3	Probably 4 Unknown
s bec	Completed	<u>.</u>					24a. Was autop	an 24b. We	ere autopsy findings available
He The lav te has ege 2	Ē						perfor	med? de: 24⊡ No 1 □	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
	0	25. Was case referred to medical				26. Place of De	ath (Check only o		Daughters
	L C		Hospital: 1   Inpatien	t 2 ER/Outpatie	nt 3 DC	Other: 4 Nursing	Home 5 ☐ Resid	lence 6 <sup>X</sup> Other	(Specify Residence
<u>o</u>	17		28a. Date of Injury (Month, Day	Year) 28b. Time o	of 2	8c. Injury at Work?	28d. Describe h	ow injury occurred	1
ndin ath. r: Aft	1	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		,,	м	1 ☐ Yes 2 ☐ No			
DIVISION I or Attendin efter death. Director: Af I in by the fun	191	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st (Specify)	reet, factory	v, office	28f. Location (S City or Tow	Street and Number n, State)	or Rural Route Number,
Ltal or rs effer al Dirre ed in I	Cortification.	3	5						
DIVISION To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	loci	29a Certifier 1 Certifying Ph	ysicien: To the best of	f my knowledge, dea examination and/or in ed	th occurred nvestigation	at the time, date and place, in my opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manr date and place, an	ner as stated. nd due to the cause(s)
To the within 2 To the complet		29b. Signature and title of certifier				c. License number			(Month, Day, Year)
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K (3)	/	30. Name and address of person who courtis Harris, M				e 300, Anna	oolis. MT	21401	
	C.	Of Data filed (Month Day Your)	2. Registra		, 50		,,		
	State istra	ALIC O 4 200C	Kendy	K Ka					

State of Maryland / Department of Health and Mental Hygiene 28618 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2<u>006</u> Month **Physician** 20, 5:50 p Grace Prencipe Show Aug. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Magnolia Center Nursing Home Lanham 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 10/4/1919 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 20 F Yrs. 86 Washington, Director 213-12-1016 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Examination to intentive the intities of 1X Yes 2 No Directo Maryland Prince George's Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20706 8200 Good Luck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Business Clerk 12 filed permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Landini Michael Prencipe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7301 Good Luck Road, New Carrollton, MD 20784 Jennie Bauer - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8/25/2006 Brentwood, Maryland \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Dicensee 4739 Baltimore Ave., Hyattsville, MD 236. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisyonly one cause on each line. Approximate Interval Between Onset and Death ANTERIOSCIENOTIC Immediate Cause (Final disease or condition ANDIOVASCULAR DISCASE RAND **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page Sucrol 5 +744 4 2. No 1 ☐ Yes 2 ☐ No certificate 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D01852 8/23/2006 ne and address of person who completed cause of death (Item 23a) (Type, Print) Queensbury Rd/dya thu: 110 Mb 20781 DRE 31. Date filed (Month, Day, Year) 3. Registrar's Signature State AUG 2 4 2006 Registrar

		•	1 - For State Registrar	State o	f Ma	ryland / Depa <i>Cel</i>	artment of H			iene UU 19. No.	<i>j</i> 0	201	כוס
			1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month		Year	3. Time o	of Death
	Physici /Medic		Mary Helen Scr	iber					August		Teal	9:20	АМ
	Examin	1.	4a. Facility Name (If not institution, give s	treet and nu	nber)		4b. City, Town, or	Location of Death		4c. County of	of Death		
			Clinton Nursing &	Rehabi	lita	ation	Clinton			Princ			
-	Funeral		Social Security Number     6. Sex	M 2∏F		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State try)	or Foreign
jār -	Director		5/9-44-6/64	IN ZXI	71	Yrs.			Sept. 1	0,1934	Mary	Land_	
	and		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town or Lo	ocation				1	0d. Inside C	City Limits
	danyl f • hc	ō	Maryland St. Mary'	_		Mechanics						1 🗆 Yes	s 211 No
	188-	Director	Maryland St. Mary	5		Mechanics	10f. Zip Code		10	0g. Citizen of W	hat Cour	try?	
	3a or	ā	40450 Kavanaugh Ro	ad			20659			Unit	ed S	tates	
	me 2	Funeral		12. Was Dec			Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race	- Americ	an Indian,	
S	r ite	Ē	1 Never Married 2 Married	Armed Fo	21 No		If Yes, specify Cuba		Rican, etc.)		, White,		
03	ei', o	þ	3X Widowed 4 □ Divorced	If Yes, Gir Year or D	/8		1 ☐ Yes 2 No	Specify:		Specify:	вта	2K	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examinat mounts in difficial at	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece	dent's Usual Occupa	ation furing most of work	ina	16b. Kind of Bus	siness/Inc	lustry	
21	within ene.	npidu	Elementary/Secondary (0-12)	College (	1-4or 5+	)	kind of work done o DO NOT use retired,						
2	e filed w ti Hygier other th		8			Cook		40. Mathada Nasa		Board of		ıcatio	on
P	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name		Maiden Sumame	9)		
Z	2 should be 1 and Mentai I is marked o raumatic eve	၉	Augusta William B	2				Mammie I				0 ()	
Maryland	12 st h and 7 is n	11	19a. Informant's Name/Relationship (Type				ng Address (Street a						
	s 1 and 2 should if Heelth and Men item 27 is marke other traumatic		Veronica Scriber / 20a. Method of Disposition	Daugh	ter	20b. Place of Dispo	Kavanaug			IIIe Ma 20c. Location - (	_		)659
Baltimore,	8° = 5		1   Burial 2 □ Cremation 3 □ R	emoval from	State	cemetery, crei	matory`or other place	θ)			•		
Ħ	Depertment Depertment Important: any injury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License		1	Charles		9/2/2		Leonardi			
Bal	permit. Depertmitimportal mportal any inju		Kyle S. Simons	M012	06		2. Name and Addres 2955 Holl						
			23a. Part1. Enter the disease, or compli								, riai	Approxima	
			shock, or heart failure. List only or Immediate Cause (Final	e cause on e	ach line		£ 1		or respiratory arre	331,		Interval 8e Onset and	etween
	Physician /Medical		disease or condition resulting in death)	·Ca	70	ac ar	ghylkm	716					
	Examiner			CC/	(or as a	consequence of):	0						
		ē	Sequentially list conditions, if any, leading to immediate		(or as a	consequence of):	(	0 1		Λ			
	uted s nnsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CO.	·/~	of Ohi	Frectobs	e Pul	mona	n OB	ne		
Ć.	n and	Еха	resulting in death) Last	Due to	(or as a	consequence of):	0.0	<del></del>		-			
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai											
9	iffication of physical as the	ed	100										
Вох	eath certifi attending I for use as	5	23b. was decedent pregnant	3c. If yes, ou			Ectopic pregnancy			23d. Date		-	
	the attr hed for	Physician/Me	in the past 12 months? 1 🗆 Yes 2 💆 No		ant at t		Other (specify)			Mon	th	Day	Year
P.0	that the d ed by the detached	hys	9 ☐ Unknow#	9LI ONKI	OWN				-	_			
	igned be de	by	Part II. Other significant conditions cor	tributing to d	eath but	not resulting in the u	inderlying cause give	Part I.		acco use contri		_	
Vital Records,	w requir been si should	Ped	Eno stage 10,0	rend	sca	se, 110	di mona	x agrici	1 1 Ye	s 2 No	3 🗌 Prob	ably 4 🔀	Unknown
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Œ		Com	Stage 4 decole	the	ill	for Ost	eg myel	try of sac	perform	ned? d	eath?	2 No	
ita	iclen: Th certificete rector, pag	Be	25. Was core referred to medical examiner?	COPU	7	minia	ang odlan	26. Place of Deat					
of V		5	1 ☐ Yes 2 🔀 No	lospital:	Inpatien	t 2 ER/Outpatie	nt 3 DOA Othe	er: 4 🔀 Nursing Ho	me 5 🗆 Reside	nce 6 Othe	r (Specify	")	
0	ding Ph th. After th tuneral		27. Manner of Death  1 SNatural 5 □ Pending	28a. Date (Mon	of Injury th, Day	Year) 28b. Time o	f 28c. Injury Work	at c?	28d. Describe ho	w injury occurre	d		
Sio	Attending redeath.	cati	2 Accident investigation				M 1	Yes 2 □No					
Division	after death Director:	Certification:	3 Suicide 6 Could not be determined			ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (St. City or Town		r or Rura	l Route Nun	nber,
	urs al urs al gral D			M									
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the ner: On the b and man	asis of	f my knowledge, deat examination and/or in ed.	n occurred at the time vestigation, in my or	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and mar ate and place, a	nner as si nd due to	ated. the cause(	(s)
	o the	Me	29b. Signature and title of certifier		3141		29c. License	e number	2	9d. Date signed	(Month,	Day, Year)	
	- > F 0		1 has	7/		m.D	. DC	05173	38	8120	913	1006	
1	~		30. Name and address of person who co	mpleted cau	se of de	ath (Item 23a) (Type.	5			0 /	, , -		
2	N	0.3	RAE T. AUNG,	24435	M	ERVELL I	BAN RD	HOLLYI	voon, n	nd 206	36		
13 m	Sta Regist		31. Date filed (Month, Day, Year)	6 Ken	Registra	r's Signature	de la						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28620

		I- For State Registrar		Certifi	cate of I	Death		F	Reg No	000 2002
Physicia		Decedent's Name (First, Midd	e,Last)					Date of Dea     Month		3. Time of Death
Medical Exami	ner.	Allen Wayne	Smith, Si					August 2	8, 2006	2322 hrs
-		4a. Facility Name (if not institution	n, give street and n	umber)		. City, Town, or L		Death	4c. County o	
		Route 235 and Park F	Pines Drive			Lexington Pa	ırk		St. Mary	S
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under :	24Hrs. 8. Date of B	rth(MM/DD/YYYY)	
Director			1 XM 2 F		Yrs.	Months Days	Hours	Min.	45 3065	Foreign CountWashington
	-	219-02-0040	1 AW 2 F	38	115.			October	15, 1967	-D.C
ž.	ŀ	Usual Residence of Decedent  10a State 10b. County		10c. City, Tov	vn or Locatio					10d. Inside City Limits
w ai		Tod Grand								1 Yes 2 X No
Maryland 28a-f show any d at once.	ğ	Maryland Saint	Marys	Ca	<u>liforņ</u>					
Mary 28a- d at	e	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
the la or	ō	45893 South Sp	ringsteen	Court		20619			USA	
death with the Maryland or items 23a or 28a-f sho	Funeral Director	11. Marital Status	12. Was De	ecedent Ever in U.S.				? (Specify Yes or N	o- 14. Race - White	- American Indian, Black,
leath r iter	ΞI	1 Never Married 2 M	arried 1 X Yes	Forces?	11 16:	s, specify Gubari,	iviexican, r	uerto Rican, etc.)	vviiite,	, 610.
ifter il", o		3 Widowed 4 X Div	orced If Yes, Give Ye or Dates:	ear	1 🗌 🔪	res 2 X No	specify:		Specify:	White
hours after 'natural'', Exaniner	q p	15. Decedent's Education (Spe		ade completed) 16		Usual Occupation			16b Kind of Bus	iness/Industry
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0036 within 72 eer than Medical	핕	12			Bookb	inder			Pri	nting
15-00 illed with Hygien d other the Me	हि	17. Father's Name (First, Middle	, Last)	<u> </u>	20,0111		B.Mother's	Name (First, Middle,		
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Be (	Walter Crouse	Prentice				lice	Marie Bre	emner	
Z = 2 = 3	2	19a Informant's Name/Relations		1	19b. Mailing			er or Rural Route Nu		ı, State, Zıp Code)
MD Ad 2 shot alth and 1 is 1 aumatic		Michele Prentis	s/ Sister	- 4	45893 S	outh Sprin	gsteer	Court Cal	ifornia MD	20619
re, ML s 1 and 2 s of Health au If item 27	-	20a Method of Disposition		20b. Plac	e of Disposit	ion (Name of cem		Date		City or Town, State
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		1 X Burial 2 Cremation	n 3 Removal	from State Mary L	and Vete	er place) eran 'S		September		M 1 1
tant		4 Donation 5 Other S	pecify:		<i>J</i> emeter	У	- CE 102 - 1	5, 2006	Cheltenh	am, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signal re of Funeral Service	Licensee		Ma	me and Address ttingley-0	ardine	er Funeral H	ome, P.A.	
		23a. Part I. Enter the disease, or	ri fanc	liner J				et Leonardt		
Physician /Medical		failure. List only one cause		caused the death. Do	not enter the	e mode or dying, s	ucii as cai	diac of respiratory at	rest, shock, or riea	Between Onset and
Examiner	ı	Immediate Cause (Final disease								Death
		or condition resulting in death)	Due to (or as	a consequence of):						
	<u>.</u>	Sequentially list conditions,	b	a consequence of):						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	*	a consequence or).						
	аш	(Disease or injury that initiated events resulting in death) Last		a consequence of):						
uted nd ransi			d							
760, ficate be executed g physician and the burial - transit	n/Medical	UNPENDED	AMENDED	1						
8760, tificate be ng physic as the bur	Me	IF FEMALE:	23c. If yes	, outcome of pregnan	cy			-	23d. Date of	delivery
187 rtifici	/u	23b. Was decedent pregnant in t past 12 months?	he 1 Live	birth	2 Feta	al death 3	Ectopic p	oregnancy	Month	Day Year
Sox 68 leath cert e attendir	sicia	1 Yes 2 No 9 Un	kanya	gnant at time of death	5 Oth	er (Specify)			1	
Box 68 te death certi	Phys		0 01111	nown						
od by etach		Part II. Other significant condi	tions contributing	to death but not resul	ting in the ur	iderlying cause gi	ven in Part			bute to the cause of death?
res the signe	d by							\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	es 2 <b>V</b> No 3	Probably 4 Unknown
ords, w requir is been s should!	Completed							24a. Wa:		Vere autopsy findings available irior to completion of cause of
co e has ge 2 s	ш						-	perf	ormed? d	eath?
tal Rection: The certificate ector, page		05 M/	- 1			26 Pleas	of Dooth (C	Check only one)	2 NO 1	Yes 2 No
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Division of Vital Records, P.O. Box 68760, within 24 hours after death ortificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Medical		and manner	s of examination and/o	or investigation			urred at the time, dat		
F × F 5	ž	29b. Signature and title of certif	er			29c. License	number		29d. Date signe	ed (Month, Day, Year)
1		45. [].	m -/-	Ollol.		O.C.N	Λ.E.		August 29,	2006
h. m	1	30. Name and address of perso	n who completed ca	use of death (Item 23	a)					
4	1 10	Patricia Aronica-Polla	ak MD. Assis	stant Medical Exa	aminer	111 Penn Str	eet, Bal	timore, MD 212	01	
,	tate	31. Date filed (Month, Day, Year	32	Registrar's Signature	1	M .		•	<del></del>	
Regis		AUG 3	2006	believe D.	Apple					

		•	For State Registrar	State of Mai	ryland / De C	eparti C <i>ertif</i>	ment of He ficate of D	ealth ar Death	nd Menta	l Hygie Rag.	ne 2006	28621
	Physici	an	Decedent's Name (First, Middle, Last)						2. Dati	e or Death	Dav Year	3. Time of Death
	/Medic	al	Dorothy  4a. Facility Name (If not institution, give s	Virginia			ith  D. City, Town, or I	Location of		gust	21 2006 4c. County of Dea	
	Examin	er	Fairfield Nursing				Crownsv				Anne A	
	Funeral Director		217-09-3900	7. Age	(In yrs. last birthe	M	f Under 1 Year lonths Days	Hours	Min. (Mo	e of Birth nth, Day, Ye 20 1	9. Bi 918 Mar	rthplace (State or Foreign ountry) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locati	ion					10d. Inside City Limits
	a-f sh	tor	MD Anne Aru	ınde1	Riva							1 ☐ Yes 🏋 No
	or 28	Direc	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	country?
	eath w	Funeral Director	3063 Centre Road	12. Was Decedent Ev	ver in II S	13 Was	2114		in? (Specify Ye	s or No-	USA 14. Race - Am	encan Indian
036	urs after d	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:			s Decedent of His es, specify Cuban Yes 2 X No	Specify:	Puerto Rican,	etc.)	Black, Wh	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then *nature!; or items 23a or 28a-f show event, ite Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)		) (7	Give kind life. DO	t's Usual Occupat d of work done du NOT use retired)	tion uring most o	of working		ard of E	
2	e filed with Il Hygiene. other ther vent, It e k	e Co	12 17. Father's Name (First, Middle, Last)		Sec	creta		18. Mother	's Name (First,			ducation
Maryland	Mental I	To B	Benjamin F. Sears					Mabe1	Harris	son		
lary	2 should be and Mental is marked of raumatic ever		19a. Informant's Name/Relationship (Ty					_			ty or Town, State,	Zip Code)
	1 and Health em 27 ther t		Thomas A. Smith II	I (Son)			entre Ro on (Name of ory or other place		Civa, Mi Date		Location - City o	r Town, State
Ē	Pages ent of nt: if it ry or o		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			ory or other place mer Cem.	1	3-24-200	)6 A	nnapolis	- MD
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: if Item 27 is marked eny injury or other traumatic es 80ca.		21. Signature of Funeral Service Life Ins	<del>90</del>	Tucilor	22. Na H	ame and Address ardesty	of Facility Funer	al Home	e, P.A		
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t ne cause on each line	he death. Do no							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Failure	to	rive						Onset and Death
	Examiner			Due to (or as a	consequence of	):						
	7	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a	consequence of	).						-
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_		(3)	IF FEMALE:	0. 11								
O. Box	he death certifi / the attending   ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death		topic pregnancy ther (specify)				23d. Date of de Month	elivery Day Year
rds, P.	quires that the de n signed by the a lid be detached f	ρ Δ	Part II. Other significant conditions con	ntributing to death but	t not resulting in t	he unde	orlying cause give	n in Part I.	23	e. Did tobac 1 ∐ Yes	1	to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	The law requires that the set has been signed by the page 2 should be detache	Completed							_	a. Was an autopsy performed	? death?	autopsy findings available completion of cause of
Vita	Physicien: The la r this certificete her aral director, page 2	Be	25. Was case referred to medical examiner?	doenital:			Otho		of Death (Chec			
ō	Physi r this c ral dir	7:1	1 Yes 2 No	lospital: 1  lnpatien 28a. Date of Injury (Month, Day			3 □ DOA Othe 28c. Injury Work	4 Cypinurs			e 6 Other (Sp	ecify)
on	ath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inj	ury		? ′es 2 ∐ N	lo			
Divis	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifice itely filled in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	n, street,	, factory, office		28f. Loc Cit	cation (Stree y or Town, S	t and Number or F itate)	Rural Route Number,
	To the Hospital within 24 hours a Yo the Funeral Completely filled	Medical (	29a. Certifier (Check only one) 1 Cartifying Physical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/	death oc	ccurred at the time tigation, in my op	e, date and inion, death	place, and due n occurred at th	to the caus e time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	To the	Σ	29b. Signature and title of certifier				29c. License			29d.	Date signed (Mor	nth, Day, Year)
)				11.1			0389			18	12216	
	3		30. Name and address of person who co	impleted cause of de	108 C.		Lighway	Slo	alon	Run	re MD	21061
	Sta		31. Date light (Month, Day, Year) AUG 2 3 200		r's Signature		J			-14.11	14/10	7.00
	Registi	rar	HUG & 3 ZU	V James	No. V	A CONTRACTOR	V V					

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The part of the pa		d within giene. or then "	omple	Elementary/Secondary (0-12)	College		life.	DO NOT use r	tired)			tobac	co pro	ducts
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Physician / Medical Examiner  Physician / Medical Examiner  23a. Fartt. Enter the disease, or confolications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest, interval between the mode of drying, such as cardiac or respiratory arrest, interval between the mode of drying, such as cardiac or respiratory arrest.    Approximate interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest.    Approximate interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the mode of drying, such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arrest. Interval between the such as cardiac or respiratory arre	Ē									8/30	/06 I	lager	stown,	Maryland
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Physician / Medical Examininer and the cause (Final death / Medical Examiner)  Sequentially list conditions, if any, leading in death) Last  Proposed as expected to medical and events are resulting in death) Last  Topic for as a consequence of):  Due to (or as a consequence of)				23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that one cause on	caused the death								Approximate Interval Between
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Certifier (Shock only one)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	<u>ta</u>		0						26. F	Place of Dear		-	1 103	20140
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cynthia Kutther-Sand, no D47451 august 27, 2006	Divisi	0 1	ertifica	3 ☐ Suicide 6 ☐ Could not b	286. Pla	ce of Injury - At he ding, etc. (Specif	ome, farm, st y)	reet, factory, o	fice				lumber or Ru	ral Route Number,
cynthia Kutther-Sand, no D47451 august 27, 2006		Hospita 24 hours Funersi stely fillex		(Check only 2 Medical Exa	miner: On the	basis of examina								
		To the within To the	Me		<i>)</i> .		1						-	
State Registrar  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nursing Home, 154 North Artizan Street  Cynthia Kuttner-Sands no Williamsfort Williamsport, Maryland 21795  31. Date filed (Month, Day, Year)  ALIG 28 2006  32. Registrar's Signature  ALIG 28 2006	1													
State Registrar  31. Date filed (Month, Day, Year)  ALIG 28 2006  Alignous D. Aparket	الحد	4-15		30. Name and address of person who Cynthia Kuthar	completed ca Sands	use of death (Iter	n 23a) (Type,	Print) Nu	rsing	Home	, 154 No	orth	Artiza	an Street
				31. Date filed (Month, Day, Year)	2006 32.	Registrar's Signa	d.	parket			7.10	~1. Y 1		- 1.10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per doc 859 9-8-06 by and Mental Hydiene

		1 - State Registrer			animent of Healt rtificate of Dea	th	Reg. No.2	2862
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last Robert Le	ee So	ocia	4.05.7	2. Date of Month Aug 10	, 200්රී	Year 6:30am
Exami	ner	4a. Facility Name (If not institution, given Cumberland Villa No. 5. Social Security Number 6. S	lursing Center	s. last birthday)	4b. City, Town, or Locati Cumberland  If Under 1 Year   If Un		4c. County of Allegan	у
Funeral Director		376-26-4169 Usual Residence of Decedent	ex	Yrs.	Months Days Hou	rs Min. 8. Date of Month May 1	3, 1928	9. Birthplace (State or Foreig
f show	ĵo.	10a. State 10b. County  MD Allegan		City, Town or Lo	erland			10d. Inside City Limi 1 ☑ Yes 2 ☐ N
a or 28a- be notif	Director	10e. Street and Number			10f. Zip Code <b>215</b> 0	12	10g. Citizen of W	•
liene. r then "naturel", or tiems 23a or 28a-f show the Madical Examinar must be notified at	by Funeral	80 Auburn Avenue  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No  XYes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or cican, Puerto Rican, etc.)	No- 14. Race Black	- American Indian, , White, etc.
r than	Completed	15. Decedent's E. (Specify only highest grant Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occupation kind of work done during i DO NOT use retired) nvestigator	most of working	Detroit Ed	
o d o	To Be (	17. Father's Name (First, Middle, Last, Clayton Socia			Ni	other's Name (First, Mide na Lathrum	Socia	•
and a m		19a. Informant's Name/Relationship (	Type, Print) <b>wife</b>	19b. Mailin	ng Address (Street and Nu uburn Avenue	mber or Rural Route Nur Cum	mber, City or Town, S nberland	State, Zip Code) MD 21502
0		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specif	II IGIIIO VAI II OIII SIAIG	Place of Dispo cemetery, crei arpelli Fui	osition (Name of matory or other place) neral Home, P.A	Date 8/10/200		own MD
Department Important: If any injury or once.		21. Signature of Funeral Service Licer	MM	22	2. Name and Address of Fa Scarpelli Fur 108 Virginia	acility neral Home, P.A Avenue; Cumb	A. erland MD 2	1502
ıysician Medical		23a. Part : Enier the disease, or come shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pligations that caused the decone cause on each line.  a	broves	ter the mode of dying, such	as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
B physician and streams the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a conse  c.  Due to (or as a conse  d.					
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gned be de	by	Part II. Other significant conditions (	contributing to death but not re	esulting in the u	inderlying cause given in P			bute to the cause of death?
certificate has been si rector, page 2 should	Completed					24a. W au pe 1 □ Ye	utopsy pr erformed de	ere autopsy findings availa ior to completion of cause o ath? Yes 2 \( \) No
S 0	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatier	Othor	Nursing Home 5 R		r (Specify)
r death. ector: After this certific by the funeral director,	atlon: T	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury at Work? M 1 Tyes 2		be how injury occurre	d
n it de	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, sti cify)	reet, factory, office		n (Street and Numbe Town, State)	r or Rural Route Number,
4 hours a Funeral D tely filled i	edical (	29a. Certifier 12 Certifying Pt (Check only 2 Medical Examone)	nysician: To the best of my kr niner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time, date vestigation, in my opinion,	e and place, and due to t death occurred at the tim	the cause(s) and man	ner as stated.  nd due to the cause(s)
9 9			//		29c. License numb	ner	29d. Date signed	(Month Day Veer)
within 24 ho To the Func completely f	Σ	29b. Signature and title of certifier			1367C		AUG.	-10, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ankered 1 tem 1 per doc 9859 9-8-06 vt. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 6 28624 Certificate of Death GEORGE ROBERT SKIDMORE SR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year SKAMORE, SI. Robert 0800 A M Ang 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BaltIMORE VA NA Medical Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 01-22-1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 579-16-3679 86 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Tyes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8209 Grainfield Road 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1941 If Yes. Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Repairman Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank R. Skidmore Manila White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McAfee - daughter 8209 Grainfield Road, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stonewall Memory Gar! 09-02-06 Manassas, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8521 Sudley Rd., Manassas, Va. 20109 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death

Physician /Medical Examiner

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page 2 should

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certificate

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i Director: A
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within 24 hours To the Funerel

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To the Hospitel or Attending Physicien:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28e-f show

iteme 23a death v

Director

Funeral

þ

Completed

Be

MD

injury or other treumatic event, the Medical Evants or trust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or item any injury or other treumatic event, the Medical Exerci-

Baltimore, Maryland 21215-0036

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? Hospital:

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes

Inpatient 2 No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Injury at Work? Injury

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sierton

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

29b. Signature and title of certifier NO 29c. License number 17465

Battimore

1 ☐ Yes 2 ☐ No

2006

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 5 2006

Bernalette C.

32 Registrar's Signature

10 N.

DHMH 17 Rev 1/2001

**ORIGINAL** 

greene St

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Man		artment of rtificate o				ene g. N.Z.	006	28625
	1 7 9		Decedent's Name (First, Middle, Last	")					2. Date of Death Month	Day	Year	3. Time of Death
757	Physici /Medic		Douglas Allan	Turner					August	25	2006	8:50 P
	Examir	- 4	4a. Facility Name (If not institution, give			4b. City, Town	n, or Loca	tion of Death	1	4c. C	ounty of Death	
100			137 John St.					stown			Washir	
	Funeral		Social Security Number     6. Se	x 7. Age (/	n yrs. last birthday	If Under 1 Ye   Months   Da		urs Min.	(Month, Day,			place (State or Foreig htry)
	Director		212-50-8429 Usual Residence of Decedent		58 <sup>Yrs.</sup>	<u> </u>			Sept. 9.	1947	Mar	yland
	and wo		10a. State 10b. County	11	Oc. City, Town or L	ocation					1	10d. Inside City Limits
	Mary	ğ	Maryland Washi	naton		Hane	ersto	wn				1 ☐ Yes 2 💢 No
	28e	rec	10e. Street and Number	ingron		10f. Zip Cod			10	g. Citize	n of What Cour	ntry?
	3a o	0	137 John St.				2174	0			l	JSA
	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-1 show the Medical Everiti ar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent			pecify Yes or No- o Rican, etc.)	14	. Race - Americ	can fndian,
9	after or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 🛣			o rican, etc.)		Black, White,	etc.
<u></u>	ours	d by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:		10 165 22	140 Spe	жиу.		3	pecify:	White
5	72 h Inetu	Completed	15. Decedent's Edi (Specify only highest grad		(Give	edent's Usual Oc kind of work do	one during	most of wor	king	6b. Kind	of Business/In	dustry
2	Mithin ne.	d d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use re		م الع	1	00 <b>+</b> h	er Prod	occina
N	filed v Hygie other t		9 17. Father's Name (First, Middle, Last)		R	eceiving			ne (First, Middle, N			essing
auc	ntal h	Be		T					tte Scot		330)	
Ē	should nd Men marke umatic	우	Claudius Preston  19a. Informant's Name/Relationship (7		19h Mail	ing Address (Str			ral Route Number,		Town State Zir	Code)
Maryland 21215-0036	d2s th an treur		Barbara Ragland -			-			own, Mary	-		
	1 and Health tem 27		20a. Method of Disposition		20b. Place of Disp	osition (Name of	f	90.0.0			tion - City or To	
ē	Pages nent of int: if it iry or o		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other		1	30 2006 6	m:+h	chura M	Maryland
altimore,			21. Signature of Juneral Service Licen						30,2006 S me, P.A.	1111111	Sbui g,	iai y rano
8	permit. Depertrimportri		Mort 5	Alle.					ue St. Wi	Ilia	msport,	MD 21795
			23a. Part. Enter the disease, or comp	lications that caused th								Approximate Interval Between
	Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	a cano	2081						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	/	xv						1 years
	Examiner	è		Obs	tructi	ve Lu	na	DIS	ease			4-ears
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):							1 - / -
	Attending Physician: The law requires that the deeth certificate be executed rideath. I cleath. ector: After this certificate hes been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated events	C.								
oʻ	an ar		resulting in death) Last	Due to (or as a c	consequence of):							
8760,	ite be iysicli ne bu	cai	(	d								
9	ng ph	Physician/Medical	IF FEMALE:									
Вох	th ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [		□Ectopic pregna	ancy			23	d. Date of defive Month	ery Day Year
	e dee he at sed fo	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant at tin 9□ Unknown	ne of death 5	Other (specify	/)				MOHIII	Day real
<u>Р</u> .	w requires that the deeth certific been signed by the attending p should be detached for use as	Ph	9 Unknown					3-44	220 Did tob			ha assume of death?
	igner bed	þ	Part II. Other significant conditions co	SCLL 0		underlying cause	given in r	-ап т.	1 X Ye		No 3 □ Prot	he cause of death? Dably 4 □Unknown
oro	requi	Completed	#/ 170	-0010	313						140 3 7 7 101	Jably 4 Donkhow
ec	law les b	pldu							24a. Was ar autops	/	prior to co	opsy findings available impletion of cause of
<u>=</u>	The page	Co							perform 1 Yes 2	No.	death? 1 ☐ Yes	2□ No
Division of Vital Records,	clan	Be	25. Was case referred to medical examiner?	Line and the first				Pface of Dea	ath (Check only one	9)		
5	hysi this c	2	TU Tes 275 No	Hospitaf: 1 Inpatient	2 ER/Outpatie	AND SELECTION		Nursing H			Other (Specia	(y)
n c	ing F After uner	Certification:	27. Manner of Death  1 ★Naturaf 5 ☐ Pending	28a. Date of fnjury (Month, Day Y	'ear) 28b. Time Injury		Injury at Work?	ما الم	28d. Describe ho	w infury	occurred	
Sic	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be		Athama fam a		1 🗌 Yes	2 🗆 NO	28f. Location (Str	not and	Number of Pur	of Courts Number
$\leq$	2 # E	rtif	4 Homicide determined	28e. Place of Injury building, etc. (		reet, factory, on	ICO		City or Town	, State)	vumber or hum	ar Route Number,
	Hospital	Ö	29a. Certifier 1 Sertifying Ph	(eicina: To the best of	mu kaawladaa daa	th accurred at th	o timo do	to and place	and due to the co	(s) a		stated
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Exam	vsician: To the best of r siner: On the basis of ex and manner state	camination and/or i	nvestigation, in r	ny opinion	, death occu	irred at the time, da	ite and p	lace, and due to	o the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier			29c. Lic	ense num	ber	25	d. Date	signed (Month,	Dey, Year)
	⊢ 3 ⊢ ŏ		) La	1)		D	44	199	6	lu a	ust 2	8,2006
•			30. Name and address of person who o	ompleted cause of dear	th (Item 23a) (Tune	Shint)		1		0	-( )/	
jh.	1-3		30. Name and address of person who can also a can also	KMD	203/1	Lappan	SRA	1 13	ounsbor	0	MD .	21713
15	St:	ite	31. Date filed (Month, Day, Year)	. 32 Hedistrars	Solonatura		<u> </u>					
35	Regist		AUG 28 20	06	. B. A.	railes						
DH	MH 17 Rev 1/2	001	AUG & O ZU	Jane Jane	11							

(Access)			1 - For State Registrar		Marylar	-	artment of F rtificate of			Reg. No	2000	5 2	86	26
	Physici	an	Decedent's Name (First, Middle, La	st)					2. Date of Month	Death Da	y Yea		Time of D	
	/Medic	al	TSHTMUN YL  4a. Facility Name (If not institution, giv	SHIBEM			4h Cih Taua	al anation of D	08	16	. County of De		102	₽M
1	Examin	er	3113 Eagles Nest		) <del>G</del> I)		4b. City, Town, o		rea(r)		Prince		CAC	
	Funeral		5. Social Security Number 6. S	ex 7	. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of	Birth Day, Year)	9.8	irtholace /	State or	Foreign
Ü,	Director		012-68-5933	<b>№</b> м 2□ F	62	Yrs.	Months Days	Hours A	July1	7,1.94	4 Bra	azzav	ongo IITe	2 ,
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ly, Town or Lo	cation					10d In	side City	Limits
	Maryl f eho	ŗo	MD Prince	Georges		wie							Yes a	
	r 28a	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What	Country?		
	th with	al D	3113 Eagles Nest	Drive			20716				USA			
	r dea	Iner	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin' an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ar Black, Wi		lian,	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dat			1 ☐ Yes 215 No	Specify:			Specify: B			
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-f ehow its Medical Examinar miss be motified at	edt	15. Decedent's E			16a, Dece	dent's Usual Occup	ation		16b. K	ind of Busines	s/Industry		
212	hin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4	Ior 5+)	(Give	kind of work done of DO NOT use retired	during most of f)	working	177				
2	ed wit	Completed		5+		C1e	rk			P	rivate			
ī	be fill Hy od oth	Be	17. Father's Name (First, Middle, Last,						Name (First, Mide	dle, Maider	Sumame)			
2	hould d Mer marke matic	10	Wagandu Tshi  19a. Informant's Name/Relationship (	.bemba		10h Mailir	a Address (Street	Dukun		lana	Town State	7:- 0	1	
Maryland	th and 2 s lith and 27 ion 1		Aissata Conde/ Wif	,, ,			eg Address (Street Eagles N					, <i>Zip</i> Code,	,	
ē,	s 1 ar if Hea item	1	20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date		20716 ocation - City	or Town, Si	tate	
altimore,	Page nent o nnt: if ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil		ate	-	Mem. Pa		25/2006	Syl	esvill	e, Ma	ry1a	and
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Importent: If Item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Evantical met must be notified at once.		21. Signature of Funeral Service Licer	1500	11	22	. Name and Addres	ss of Facility	J.B. Je	nkins	Funer	al Ho	ome	
<u> </u>	20 E 2 9		23a. Part1. Enter the disease, or com shock, or heart failure. List only	-ha	$U_{-}$		474 Land				MD 20	785		
	Physician /Medical Examiner physicien end the prinal-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (o	r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of a cons	uence of): uence of):	MUER	CAN	OCE R			Olise	t and De	<b>Ja</b> (1)
). Box 68760,	death certifii e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 □ Feta nt at time of d	ideath 3	Ectopic pregnancy			_	23d. Date of d Month	elivery Day	Ye	ear ear
P.O.	that the de ned by the a detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions of			ultina in the	da di da di da di da di da di da di da di da di da di da di da di da di da di da di da di da di da di da di da	1: B. at	22- 5		use contribute	4- 4b		
	w requires that been signed is should be det	d by		CLTUS	-		idenying cause giv	en in Part I.		Yes 2		ro the caus		
Sor	v requ been shoul	etec	HY PERTEN SI	- 1.77	1116						_			
Division of Vital Records,	The ia	Completed		.0.0					24a. W at pe	itopsy erformed?	death	completic	on of cau	use of
Ĭ	Physician: rthis certifica ral director, I	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 🗆 Ing	nationt 2	ER/Outpatien	t 3 DOA Oth	0.00	Death Check on		6 Flother (6-			
0	g Physie this seral di		27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Injun Work		28d. Describ			еспу)		
joi	Attending ir death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	1	Day rear,	Inquiry		Yes 2 □ No						
Divis	tal or Attendents efter deatlai Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place 0	Injury - At he , etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location City or	n (Street ar Town, State	nd Number or i	Rural Route	e Numbe	₿ <i>Г</i> ,
	To the Hospital or Attending I within 24 hours efter death.  To the Funeral Director: Atter completely filled in by the funer	edical	29a Certifier 1	yeicien: To the b niner: On the bas and manne	is of examina	wladge, death ition and/or inv	vestigation, in my o	ne date and pl pinion, death o	ace, and due to to occurred at the time	he causa(s ie, date and	and manner diplace, and d	ae clatud. ue to the ca	ause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	)		29c. License			1	te signed (Mo	-		
,			Hamall	uses	-	nus	DS&C	79	12 12 miles	Au	GUST	14,5	006	
2	(2)		PRACINE HIGGS — S		of death (Item	n 23a) (Type,	Print) (( COUPY	. LARC	GO, MADL	(Au				
4	Sta	te	31. Date filed (Month, Day, Year)	2. Reg	nstrar's Signa			,	to land	U / VD	-			
	Registr		AUG 2 3 200	i Clas	w St	Spa	w							

State of Maryland / Department of Health and Mental Hygiena

				Olato of Mi	aryland / L	Certific	ate of		Re	200	6 2	28627	
Ī	Dhysis	ion	1. Decedent's Name (First, Middle, I	ast)				·	2. Dete of Deet Month		Yeer	3. Time of Death	
	Physic /Med		ANNA	STELLA V	WAYSACK_				SEPTEMB	ER 02,2	006	7:30 A.M.	
ı	Exami	ner	4a Facility Name (If not institution, g	ive street and number)				4b. City, Town, or L	ocation of Death	4c. County o	f Death		
			KLINE HOSPI				1-11/	MT. AIRY		FREDE			
b	Funeral Director		220-16-0047	Sex 7. Ag	e (In yrs. last bir	Yrs.	nder 1 Year hs Days		8. Date of Birth (Month, Day, MAY 8, 1	rear)	Country	e (State or Foreign SBURG, MD.	
	end *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d.	Inside City Limits	
	faho	ō	MD FREDE	DTCV		DEDED	OT.					1⊠Yes 2□No	
	158 the	2	10e. Street and Number	KICK	г	REDER I	Zip Code		10	Og. Citizen of Wi	hat Country	?	
	Sa or	Funeral Director		Cm			2170	1					
	Jeath The 2	Jera	716 N. MARKET	12. Was Decedent	Ever in U,S.	13. Was De	2170 ecedent of F	⊥ Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		- American		
Baltimore, Maryland 21215-0036	ages 1 and 2 should be filed within 72 hours eftar death with the Marylend nt of Health end Mental Hygiene. If Item 27 is marked other than "naturel", or thems 23a or 28a-f ahow or other traumatic event, the Medical Examinar must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				an, Mexican, Puerto	Rican, etc.)		WHITI		
2	72 hc	ğ	15. Decedent's	Education	16a.	Decedent's L	sual Occup	pation	ring	16b. Kind of Bus	iness/Indus	try	
7	ithin	Completed by	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)										
7	ygien t. Th	2	12			HOME	MAKER				HOME		
ב	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, La					18. Mother's Nam					
<u>X</u>	should nd Men marke umatic	ို		. SANDERS				1	BLANCHE				
<u>a</u>	2 sh end ls m		19a. Informant's Name/Relationship	(Type, Print)				and Number or Rui				ode)	
a)	1 and Health m 27 ther tr		TINA PERKINS/DA	UGHTER	20b. Place of			DR., HAG		MD. 21'		State	
ğ	Peges nent of h int: If Ite		1 X Burial 2 ☐ Cremation 3		cemeter	y, crematory	or other pla				•		
	tmer tant:	_	4 □ Donation 5 □ Other (Spec	•	NEW ST	. JOSE			5/06 E	EMMITSBU	RG, M	D. 21727	
e E	permit. Peges 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Lic					IN ST., E	MMITSBUR	_		-0427	
	Physician		23a. Part. Enter the disease, or co	est,	Aj in	pproximate terval Between nset and Death							
	/Medical		Immediate Cause (Final disease or condition	acute	ancen	holos	atte	G				days	
	Examiner		resulting in death)	a	Due to (or as e	consequence	of):	7				2393	
Ī	р .≅	je l		a Qcute b. Lacu	mar c	orebr	al i	nfares			V	nonths	
1	Attending Physician: The law requires that tha death certificate be assecuted rideath.  setor: After this certificate has been signed by the attanding physician and by the funerel director, page 2 should be datached for usa as the bunal-transit	edical Examiner	Sequentially list conditions,	В	Due to (or es a	onsequence	of):				1		
Ď,	oa axe cian s	ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c									
68/60,	cate i	9	that initiated events resulting in death) Last		Due to (or as a c	onsequence	of):						
	ding I	5		d							i		
ROX	attan for us	dan											
<u>.</u>	the d	ysi	Part II. Other significant conditions		_	•						e cause of death?	
J.	that led by data	4	Parkinson's	Syndo	ne, k	polar	c 1/1	ness,	1	s 2 No	3 ∐ Probat	y 4 □ Unknown	
S	v requires that tha death ce been signed by the attandi should be datached for use	Completed by Physician/	Parkinson's Schizophren	(	,			,	24a. Was a	n autopsy	24b. Were	autopsy findings	
င္ပ	w req	lete	Schizo phren	ia, De	mentio	<b>i</b>			perform	ned?	comp of dea	ble prior to letion of cause ath?	
T U	he lay	Ĕ		·					1 □ Ye	s 2X No		′es 2□ No	
Eg.	ification, pa		25. Was cese referred to medical					26 Place of Deal	h (Check only on			20110	
5	/sicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient 3□	DOA Ot	hor:	ome 5 Reside		r (Specify)		
5	a Physical series		27. Manner of Death	28a. Date of Inju	ry 28b. 1	ime of	28c. Inju Wo		28d. Describe ho				
0	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	on	y / 50//	М		Yes 2 □ No					
DIVISION OF VITAL RECORDS,	lor Atte efter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of Inj	ury - At home, fa	rm, street, fac	tory, office		28f. Location (St. City or Town		r or Rural A	loute Number,	
	ital or ral Dir lled in	Ce											
	To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: Affer this certificate has completely filled in by the funerel director, page 2	edical	29a. Certifier 1 X Certifying F 2 Medical Exp	Physician: To the best aminer: On the basis of and manner st	f examination and	, death occur d/or investigat	red at the ti	me, date end place, opinion, death occur	and due to the ca red at the time, da	ause(s) and mar ate and place, a	ner as state nd due to th	ed. e cause(s)	
	within To th	Σ	29b. Signature and title of certifier	^			29c. Licen:	se number	2	9d. Date signed	(Month, Da	y, Year)	
			Kathlein W	Stein MS			D32	2073	S	SEPTEMBE	ER 5,	2006	
	3		30. Name and address of person wh					^	d Mal	21711			
		ate	31. Date filed (Month, Day, Year)	20 Deniète	ada Cianatura			Ji waside	Le l'ai	-1110			
	Regist		SEP 0 8 2	2006	ars signature	Coast	2						

ORIGINAL

			For State Registrar	State of Ma	ryland / Depa	artment o		Mental	Hygien	0000	28628			
	Physici	an	1. Decedent's Name (First, Middle, Last William H. Wi					2. Date of	of Death	av Year	3. Time of Death			
	/Medic Examir	al	4a. Facility Name (If not institution, give			4b, City, Tow	n, or Location of De			c. County of Dea				
	Examili	er	Memorial Ho	spital		Cum	berlan	d		Allega				
	Funeral Director		5. Social Security Number 6. Se 216-22-6086	x 7. Age ]M 2□F	(In yrs. last birthday) 79 Yrs.	If Under 1 Ye Months Da			ካ, <i>Day</i> , Yea	r) C	inthplace (State or Foreign Country)			
	D		Usual Residence of Decedent			1		MOV.	_24,_	,1926 Maryland				
	Maryla f ehov	ō,	MD · Allegar	ıy	10c. City, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
	or 28e	Jirec	10e. Street and Number			10f. Zip Coo			10g. C	Citizen of What C	Lountry?			
	s 23a	Funeral Director	14805 Lone Oak	St.	iver in II 6 42		502	(Cassit - Van		JSA 14. Race - Am	noisea Indian			
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heetth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other traumatic event, Ite Medical Examinal must be notified at ODGs.	۵	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N  If Yes, Give Year or Dates:	° 1946	ff Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	erto Rican, etc	.)	Black, Wh				
21215-0036	72 hou	eted	15. Decedent's Edi (Specify only highest grad	cation e completed)	1947 16a. Dece (Give	dent's Usual Oc kind of work do	ccupation one during most of w tired)	vorking	16b.	Kind of Busines	s/Industry			
121	within iene. then	Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5-	+)	<i>DO NOT use re</i> s Cutt		·	G	lass				
nd 2	al Hyg d other	BeC	17. Father's Name (First, Middle, Last) Simeon Whiten	10 N			18. Mother's N		iddle, Maide	n Sumame)	73 ' 1			
Maryland	d Ment d Ment marked matic	ဥ	19a. Informant's Name/Relationship (7)		10h Maili	og Address /Str	HATT1				Whiteman			
Ma	elth an 27 is in traus		Eunice Whitemar		ouse 1480									
Baltimore,	ges 1 a t of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other	place)	Date		Location - City o				
Ħ	artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify,  21. Signature of Funeral Service Licens				n Pk Sep				ırg, MD Service PA			
Ba	Dep imp eny	1	I Gohn J.	Hafer			ational							
			23a. Part1. Ent r the disease, or corp o shock, set eart failure. List body of	ications that caused ne cause as soch lin	the leath. Do not ent	er the mode of	dying, such as cardi	ac or respirate	ory arrest,		Approximate Interval Between Onset and Death			
1	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a. Rue to for is a	consequence of	la luge								
	Examiner		Sequentially list conditions	. Ceep	1 Viscula	· AC	esdent,	hair	ste	n				
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or a a	consequence of):		/	/						
o o	te be executed ysicien end ne burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of):									
8760	¥ × 9	dicai	(	d	-					-				
Box 6	leath certific attending p I for use es I	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				-		23d. Date of de	elivery			
P.O. B	Attending Physicien: The law requires that the death certifica rates.  I death.  ector: Atter this certificate has been signed by the attending phore the functor, page 2 should be detached for use es the funeral director, page 2.	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown		Ectopic pregna Other (specify				Month	Day Year			
	res thei Igned t be det	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause	given in Part I.	1			to the cause of death?			
Records,	w require been sly should t	Completed	- HY PETUNION	- MY	elaral .	- says	9	-	1 ∐ Yes : Wasan		Probably 4 Unknown			
	The lay	ошо						-	autopsy performed?	prior to death?	tutopsy findings available completion of cause of second 2 No.			
/ita	cien: artifica actor, p	Be	25. Was case referred to medical examiner?	tarabali M			26. Place of D	eath Check		1270	3 2010			
<del>o</del>	Physi r this c aral dire	1: To	1 ☐ Yes 250 No  27. Magner of Leath	lospital: 1 Inpatier 28a. Date of Injury	28b. Time of	IL SLI DOA				6 Other (Spe	ecify)			
ion	ttending death. ctor: Afte / the fune	atior	1 Natural 5 Pending Investigation	(Month, Day	Year) Injury	1	njury at Work? 1 □ Yes 2 □No			,				
Division of Vital	tal or Atto	Certification:	3 Suicide 6 Could not be determined	28e. Pface of fnju building, etc.	ry - At home, farm, str . (Specify)	eet, factory, off	ice		on (Street a r Town, Sta		Rural Route Number,			
	To the Hospital or Atlending Physicien: The within 24 hours after death. To the Funerel Director: Atler this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Phy	sician: To the best o ner: On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	h occurred at th vestigation, in n	e time, date and plan ny opinion, death oc	ce, and due to curred at the t	the cause( ime, date a	s) and manner a nd place, and du	is stated. le to the cause(s)			
	With To t	≥,	29b. Signature and title of certifier	1.A		29c. Lic	ense number	0	29d. D	ate signed (Mon	14			
,	641		30. Name and address of person who c	ompleted cause of the	atri (Item 23a) (Type.	Print)	11121	<i>o</i>		sept.	512 2006			
	0		Dr N. Ranjitho	n, 517	Oldtown T		Rear, Ci	imber	land	MD	21502			
	Sta Registr		31. Date fifed (Month, Day, Year)		r's Signature	land.								
DH	MH 17 Rev 1/2	001	SEP 0 8 2	UUD JORGE	w # A	market !								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUG 2°0°06 14:30 м EVELYN WRIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLADYS SPELLMAN SPEC., HOSPITAL HYATTSVILLE PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | JUNE 5, Year | 9 3 5 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) , Funeral 1 □ M 2√ F 71 Yrs. 230-38-0481 Director PULASKI, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28e-f show Ite Medical Examinar mest be political at Yes 2 No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 BENNING RD. N.E. #L-32Funeral 20002 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No þ Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5 th College (1-4or 5+) DOMESTIC HOME CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental I Pages 1 and 2 should be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau ROBERT WRIGHT/SON 10300 LEVELS RD. FREDERICKSBURG, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-19-06 CHESAPEAKE CREM. BELTSVILLE, MD 21. Signature of Funeral Service 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., D.C.20002 23a. Part1. Enter the disease, shock, or heart failure. Us complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a considuence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an page 2 s has 1 Yes 1 Yes 2 X No 2 ₩ No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 21X No tor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 XNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge death conumed at the films data and clade and due to the datase(e) and manner at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fil and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026024 8-17-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6490 LANDOVER RD. LANDOVER, MD LESTER MILES, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 2 4 2006

		•	For State Registrar	State of Maryland	-		nt of He te of D			R	eg. No.	11116	28630
	⊶ ysicia Medic		1. Decedent's Name (First, Middle, Last  Mary Bell Wa						1	Date of Dea Wonth ugust	Day	Year 2006	3. Time of Death 8:25 A <sup>M</sup>
	amine		4a. Facility Name (If not institution, give Holy Cross Ho	street and number)			Sil	Location of Dea	ring		4c.		gomery
Fun Dire	eral ctor		5. Social Security Number 6. Se 1579-40-6847		Vre	If Unde Months	Days	If Under 24 Hr. Hours Min	1. (	p. 25	, Year)	C	rthplace (State or Foreign ountry) rth Carolina
Maryland f show	ledat	JO.	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Lo	ocation		Washing	a+on				10d. Inside City Limits 1 X Yes 2 ☐ No
with the last or 28s-	Itou ed	Director	10e. Street and Number	. NII #906		10f. Z	p Code	)009 <b>–</b> 587				zen of What C	
portition of the property of the process of the pro	saminer must	by Funeral	2001 - 15th S  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, sp 1 Yes	edent of His ecify Cubar			ecify Yes or No- Rican, etc.) 14. Race - Am Black, Wh			erican Indian,
thin 72 hours.	Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Dece (Give life.	kind of w	ual Occupa ork done d use retired)	uring most of w	vorking 16b. Kind of Busin			nd of Business	s/Industry
be filed wit tal Hygiene d other thi	event, the	Be	6th 17. Father's Name (First, Middle, Last)					estic 18. Mother's Na	ame (Fir			Priv Sumame) 11iams	
2 should and Mer	reumatic	ပ	Cliff W	ype, Print)				nd Number or F		ute Numbe	r, City o	r Town, State,	
jes 1 and 1 of Health	or other t		Marvin T. Brown  20a. Method of Disposition 1 □ Burial 2 ☆ Cremation 3 □	Removal from State	lace of Dispo emetery, cre	osition (Na matory or	ame of other place	a) 1	Dete			cation - City o	r Town, State
permit. Pages Depertment of	any Injury once.		4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen	)	ee's	2. Name a	nd Addres	s of Facility Benning		wart		Clinto eral Ho sh., DC	me
Physi	cian		23a. Part1. Enter the disease, or comp shock, of heart failure. List only of Immediate Cause (Final	olications that caused the dead one cause on each line. Cardiopuln				, such as cardi	ac or res	spiratory ar	rest,		Approximate Interval Between Onset and Death
/Med Exam	dical		disease or condition resulting in death)	Due to (or as a consequentia									
betu	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq  Bowel Obst		on							
ate be executed by sicien and	the burial-t	cai	Due to (or as a consequence of):										
Ords, F.C. BOX 00 requires the the death certifical mean signed by the effending by	should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									elivery Day Year	
uires thet	ald be deta	Ď	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	underlying	cause give	en in Part I.	_		obacco ( res 2	_	to the cause of death?  Probably 4 Unknown
The law requires	irector, page 2 shot	Completed							-	24a. Was autop perfo 1 Yes	rmed?	prior to death?	
VITAL Iclan: 1	director, I	Be	25. Was case referred to medical examiner?				0.1	26. Place of D	eath (C	heck only o	ne)		
<b>7</b>	<u> </u>	ဥ	1 ☐ Yes 2 📆 No	II '	ER/Outpatie			4   1401 51119	-	5 Resid		6 □Other (Sp	pecify)
ding A	funer	Certification:	27. Manner of Death  1 ▼Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		28b. Time (	М		y at (? Yes 2 □ No					Rural Route Number,
2 9 4 5	i		4 Homicide determined	building, etc. (Special	(y) 					City or Tov	vn, State	e)	
B Hospital	etely fi	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, dea ition and/or i	ith occurre nvestigati	on, in my o	pinion, death oc	ccurred a	at the time,	date an	d place, and d	as stated. ue to the cause(s)
To the within 2	сошр	Me	29b. Signature and title of certifier			2	9c. Licens		-/		29d. Da	te signed (Mo	nth, Day, Year)
\			30. Name and address of person who	completed cause of death (Itel	п 23а) (Туре	, Print)	MO	366	51.			August	6, 2006
			D. Kevin Lur	ie, M.D. 1500	Fores	t G1	en Ro	ad, Sil	ver	Sprin	ng, l	MD 209	910-1484
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	HUTE	de							

			For State Registrar	State of M	laryland / [	Department of I Certificate of	Health and M <i>Death</i>	fental Hygi Re	ene 00	6 28631	
	Physici /Medic		Decedent's Name (First, Middle     Ca	, Last) therine Reg	ina Wibl	e		2. Date of Death Month August	Day Y	ear 4:25 A M	
	Examir		4a. Facility Name (If not institution			_	or Location of Death		4c. County of		
	Funeral Director	122	St. Mary's Nu 5. Social Security Number 218-14-3107 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last bin				St. Mary's te of Birth onth, Day, Year) 11 04,1921  St. Mary's 9. Birthplace (State or Forei Country) Maryland		
yland	how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
ы Ма	8a-f s	Director	Maryland Saint M	arys	Ho11	ywood				1 ☐ Yes 2 ☐XNo	
with th	le or 2		10e. Street and Number <b>24702 Old Th</b>	maa Watab D	1	10f. Zip Code		10	g. Citizen of Wha	at Country?	
death	me 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	20636 13. Was Decedent of I	Hispanic Origin? (Sp.	ecify Yes or No-		American Indian,	
<b>21215-0036</b> d within 72 hours after death with the Maryland	nd Mental Hygiene. marked other then "natural", or Itame 23e or 28a-f show imatic event, the Medical Examinar must be motified at	þ	1 ☐ Never Married 2 ☐ Marri X Widowed 4 ☐ Divorced		<b>(</b> No	1 ☐ Yes 2 XNo	san, Mexican, Puerto	rican, etc.)	Specify:	White, etc. White	
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<b>Maryland</b> d 2 should be file	Mental Hy irked oth itic event	To Be (	17. Father's Name (First, Middle, I				18. Mother's Name Estel	e (First, Middle, M	laiden Surname)		
<b>dary</b> 2 sho	Is ma	ľ	19a. Informant's Name/Relationsh	_		Mailing Address (Street				i i	
	if Health and Menitem 27 is marke other traumatic		Joseph F. Wible 20a. Method of Disposition	e/Son	20b. Place of	560 Austin Disposition (Name of			Mary 1a		
Baltimore, permit. Pages 1 av			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemeter	y, crematory or other pla	Augus	t 28,			
alti	Department of Important: If any injury or ones.		21. Sundare of Funeral Service L	• •	PE JOH	22. Name and Addre	,		Hollywood,		
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			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that cause only one cause on each	id the death. Do n line. • O	ot enter the mode of dy	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death	
//	nysician Medical		disease or condition resulting in death)	Due to (or as	a consequence of	salory to	alling			2 days	
Ex	kaminer	_	Sequentially list conditions,	b/	Metal	olic Ho	udose	Z		4 days	
petr	nsit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	s surrisequence o	1 Fall	Person.			2 A	
O, execu	/sician and e burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	02 - 0 10	4		_	grammana	
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	the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown		t time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		Month	Day Year	
P.O.	signed by the a Id be detached f	Phy	Part II. Other significant condition	ns contributing to death I	but not resulting in	the underlying cause give	ven in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?	
ecords, P.O taw requires that the	n sign uld be	ed by	I	Vialvela	1 Me	liters				Probably 4 Unknown	
eco law re	s been s	Completed	J	Logite	nsio	n		24a. Was an autopsy		re autopsy findings available r to completion of cause of	
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of Vita Physician:	is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	oFF0:0	Ott	26. Place of Death				
of g Phy	ter this neral di	$\vdash$	27. Manner of Death	1 ☐ Inpati 28a. Date of Inji (Month, Da	ury 28b. T	patient 3 DOA	4 Wursing Hor	me 5 Residen 28d. Describe hov		Specify)	
OIVISION or Attending	death. ctor: After y the funer	catlo	1 ■Natural 5 □ Pending 2 □ Accident investig. 3 □ Suicide 6 □ Could n	ation	19 7 9617		Yes 2 □No				
DIVISION Of VITAL RECORDS, Ital or Attending Physician: The law requires t	within 24 hours after death  To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned   289. Place of In	jury - At home, far tc. (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,	
Le Hospital	n 24 hou	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the best xaminer: On the basis of and manner st	of examination and	death occurred at the till for investigation, in my o	me, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manne e and place, and	er as stated. due to the cause(s)	
To the	To the	M	29b. Signature and title of certifier	DA	1	29c. Licens	se number	296	d. Date signed (M	fonth, Day, Year)	
			par	nest la	WOEX	VI V	0641	7	8-25	-06	
			30. Name and address of berson v  J. Patrick Jarb	//		Type, Print)  Notch Road, Ho	ollywood Ma	ruland 200	36		
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State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 1 - For State Registrar 28632 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month Physician August 20 2006 10:00 ₺ Terri Wilkerson /Medical 4a. Facility Name (II not institution, give street and number) S. Riverab. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health & Rehab. Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 T F 43 214-84-4905 11 1963 I11 Jan. **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show ust be rivillied at 1 ☐Nes 2 ☐ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 635 Greenbriar Lane 21401 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. or iteme other traumatic event, the Medical Examiners Black, White, etc. tiled within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify Specify. þ 3 Widowed 4 Divorced naturai Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 US Naval Academy 12th Food Service other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) wermit. Pages 1 and 2 should be t. Department of Health and Mental Himportant if them 27 is merany injury or other. 12 should be ti h and Mental H 7 is marked otl Joyce Hudson James Wilkerson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Johnson (Mother) 635 Greenbriar La. Annarolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest 8/25/06 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wm. Reese & Sons MOrtuary, F 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee Lavy 2. Keese M60 983 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical 161ASTATIC CERVICAL CANCER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit Physicien: The law requires that the death certificate be executed that initiated events attending physicien and tor use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a P.0 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, ate has been sign page 2 should be 1 Yes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hcspital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deatl

To the Funeral Director:
completely tilled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) **Ø**gistrar's Signature State **AUG 23** 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 11 11 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 24, 2006 **Physician** Natalie Zoslosky Waschak 3:05 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Months Days Hours Yrs. Director 74 28, 1932 Massachusetts 019-24-3138 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f show if Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28e-f shov other treumetic event, It a Modical Exertinate the notified at 1 ☐ Yes 2 No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 Dancer Court 20657 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 is marked other than "netural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dietary Manager Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Conrad Zoslosky Catherine Szewczuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Dancer Court, Lusby, Maryland 20657 Frank Albert Waschak (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of the Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 8/27/2006 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jacke Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, pe 1 Yes (2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 20 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3∏ DOA (his funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0060475 completed cause of 3-ath (Item 23a) (Type, Print) 30. Name and address of person HOSPITAL ROAD, PRINCE FREDERICK MD 2067B 00 EUA 32. Registra/s 31. Date filed (Month, Day, Year) State 2006▶ Registrar

		1	For State Registrar	State of	Maryland		artment of He tificate of D		Mental Hyg	iene <sub>eg. No</sub> 2006	28634
			1. Decedent's Name (First, Middle, L	ast)					2 Date of Deat Month	Day 2006	3. Time of Death
	Physicia /Medic	_	Janie Ellen Y	oung					August	7	1:05 P M
	Examin		4a. Facility Name (If not institution, g		ber)		4b. City, Town, or		ath	4c. County of Death	
			48680 Beachville		7. Age (In yrs. la	st hirthday)	St. Ini	goes If Under 24 Hi	rs. 8. Date of Birth	Q Riet	nplace (State or Foreign
	Funeral Director		5. Social Security Number 6. 220 - 40 - 7194	1 ☐ M 2 X F	75	Yrs.	Months Days	Hours Mi		1930 Mar	yland
		l	Usual Residence of Decedent								
	how		10a. State 10b. County Maryland St. Mar	, t c		Town or Lo. Inigo					10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	Ba-f •	Cto		y 5 	50.	111150				O OW of Mines Co	
	or 2	Director	10e. Street and Number				10f. Zip Code 2068	,		Og. Citizen of What Co United Sta	
	e 23e	12	48680 Beachvill		dent Ever in U.S	13 1			(Specify Yes or No-	14. Race - Ame	
	ter de	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed For	ces?				(Specify Yes or No- erto Rican, etc.)	Black, White	
920	urs af	ρ	3 ₩idowed 4 Divorced	If Yes, Give Year or Da	9		1 □ Yes 2X No	Specify:		Specify: B	lack
21215-0036	72 hours after death with the Maryland natural; or teme 23a or 28a-f ehow deat Examiran must be notified at	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occupa kind of work done d	uring most of w	vorking	16b. Kind of Business/	Industry
21	within lene. then "	nple	Elementary/Secondary (0-12)	College (1	4or 5+)		DO NOT use retired)			Restauran	t
2	filed w Hygier other th		10 17. Father's Name (First, Middle, La	set)		Co	ok	18. Mother's N	lame (First, Middle,		
anc	ntal hed of	Be c		_					el M. Your		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, the Madical Exemples must be notified at	၉	Joseph A. Fenwic  19a. Informant's Name/Relationship			19b. Maili	ng Address (Street a			r, City or Town, State, 2	Zip Code)
	nd 2 :: 11th ai 27 Is r trau		Joseph C. Young	/ Son		P.O.	Box 123 S	t. Ini	oes MD. 2	20684	
e,	ges 1 and 2 of Health If item 27 I		20a. Method of Disposition			ace of Dispo	osition (Name of matory or other place		Date	20c. Location - City or	Town, State
altimore,	Page nent o ant: If ary or		1 ☐️Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		St.		Claver			Ridge, Mar	
alt	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Lic		The m	-				Funeral Ho	
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Records,	signed to	d by	, and an end of	<b>3</b>		J	, ,		1 🗆 Y	′es 2 □ No 3 □ P	robably Unknown
Ö		Completed							24a. Was	an 24b. Were a	utopsy findings available
Re	e la hes	E G								rmed? death?	completion of cause of 2 □ No
<u>ra</u>	ilcian: Th certificate rector, pag	e C	25. Was case referred to medical					26. Place of	1 ☐ Yes Death   Check only o		20110
Vital	Physician: r this certific ral director,	To B	examiner?	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA Oth		. /	dence 6 □Other (Spe	ecify)
J of	ding Phys n. After this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	of 28c. Injun World	y at k?	28d. Describe h	now injury occurred	
Sio	ending bath. or: After he funer	catic	2 ☐ Accident investiga	tion				Yes 2□No	00/ 1	7	Land Courts Alumbas
Division	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Place	of Injury - At hong, etc. (Specif)	ome, farm, si v)	treet, factory, office		City or Tov	Street and Number or F vn, State)	urai Houle Number,
	ospital hours a unaral I	ledical Ce	29a. Certifier Check only 2 Medical E	Physician: To the	best of my kno asis of examina	wledge, dea	th occurred at the tin	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
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	Jiji P			hot			DC 9	200			
10	$\sim$		30. Name and a d ess of person w	no completed caus	se of death (Item	n 23a) (Type		288		August 29	2006
0 /	U		Nikkal Uppal, M					lo11vwo	od, Maryla	and 20636	
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3	32. F	Segistrar's Signa	iture		•			

	1- For State of Maryland / Department of Certificate of Certificat	f Health and Mental Hy of Death	ygiene 2006 28635 Reg. No.
Physician /Medical		2. Date of D Month	Death Day Year 3. Time of Death $\frac{1}{2}$ $1$
Examiner Funeral	4a. Facility Name (If not institution, give street and number)  4b. City, Tow  Manor Care - Towson  5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yr		4c. County of Death  Baltimore  Birth Day, Year)  71920  4c. County of Death  9. Birthplace (State or Foreign Country)  Maryland
Maryland -t show fled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland be dither than "natural", or items 23a or 28a-f show event, Ire Medical Examination in the notified at Be Completed by Funeral Director	10e. Street and Number  820 S. Rose Street  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  10f. Zip Cor  21224  12. Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 No If Yes, specify 1 Yes 2 No If Yes, Give Year or Dates: 1944–46	1 of Hispanic Origin? (Specify Yes or N Cuban, Mexican, Puerto Rican, etc.)	10g. Citizen of What Country?  United States  No-  14. Race - American Indian, Black, White, etc.  Specify:  White
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Pages 1 annent of Healunt: If item 2	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Cemetery, Crematory of other Saint Stanislau	of Date	20c. Location - City or Town, State  Baltimore, Maryland
Permit. Departing myorize any injury. Bull any injury. Bull Bull Bull Bull Bull Bull Bull Bull	23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)	, Weber Funeral Ho Chester Street Bal dying, such as cardiac or respiratory	Itimore, Maryland 21231
The law requires that the death certificate be executed the law been signed by the attending physician and page 2 should be detached for use as the burial-transit to be completed by Physician/Medical Examiner.		candisvasudan	disease 57 rst
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sician: The law requires to certificate has been signe rector, page 2 should be		pe	prior to completion of cause of death? s 2 \( \text{No} \) 1 \( \text{Yes} \) 2 \( \text{No} \)
tending Physical Class. Item After this the funeral discrete	1 Tyes 2 No	Other: 4 Nursing Home 5 Re Injury at Work? 1 Yes 2 No  28f. Location	esidence 6 Other (Specify) be how injury occurred  n (Street and Number or Rural Route Number, Town, State)
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at 1 (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in	the time, date and place, and due to t	the cause(s) and manner as stated.
To the twithin 2.	29c. L  29c. L  29c. L  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	O 31 865	29d. Date signed (Month, Day, Year)
State Registra	Rm 206 821 N. Gutan Street  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Baetimore	md 2/20/

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28636

	- 1	1- For State Registrar		Certi	ificate of	Death		F	Reg. No.	000	2000		
Physicia	ın/	Decedent's Name (First, Midd	le, Last) Terrano	e Devonn	e Ross			2. Date of De Month		-	ime of Death		
edical Exami		Terrence			BLOWII			July 19, 2		19	948 hrs		
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death											
		University Hospital				Baltimore			ŀ				
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. Ias	t birthday)	If Under 1 Year	If Under	24Hrs. B. Date of B	rth(MM/DD/YYYY	9 Birthplao	e (State or		
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88			PG	Dis	own or Location	ights							
and sho	ь	MD Balti	more	- <del>Je</del>	<del>ssup</del> -					×	Yes 2 No		
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 62	00 Surrey Squa	ire Lane	# 104	10f. Zip Code	20747	7	10g. Citizen of Wh	at Country?			
	흡	P.O. Box 534		U.S.A.									
eath with the items 23a	īg.	11. Marital Status	12. Was Deced	ent Ever in U.S	13. Was	Decedent of His	panic Origi	in? ( Specify Yes or N	o- 14. Race	- American In	ndian, Black,		
eath item	Funeral	1 Never Married 2 M			If Ye	es, specify Cuban	, Mexican,	Puerto Rican, etc.)	White	, etc.			
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5-003 iled withi Hygiene I other tl	6	17. Father's Name (First, Middle	-				18.Mother's	s Name (First, Middle,	Maiden Surname)				
filed of the file		Albert Ross,						la L. Brow					
21215-0036 und be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be	19a. Informant's Name/Relations			19h Mailing	Address /Stree	t and Num	ber or Rural Route Nu	mber City of Town	n State Zin (	Code)		
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e, MD  I and 2 sho Health and item 27 is		Ella L. Ross -	Mother	20h BI		tion (Name of cen		Lane #104	20c. Location -				
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Baltimore, permit Pages I ar Department of Her Important: If ite	- 1	21. Suat re of Funeral Service			22. N	ame and Address	of Facility	Freeman Fu	neral Se	mzi coc			
Maria Da		- Aumant	TOURLAIN	)	580	)1 Cleve	land	Avenue: Ri	verdale	MD 2	20737		
Physician		23a Par I. Enter the disease of	mplications that caus	sed the death. [	Do not enter th	e mode of dying,	such as ca	ardiac or respiratory ai	rest, shock, or hea	art App	proximate Interval		
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8760, tificate be ng physicas the burnas the	/Me	IF FEMALE: 23b. Was decedent pregnant in t	to a second	tcome of pregna			_		23d. Date of	-			
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Records The law requirected that has been page 2 should	Completed							24a. Wa auto			findings available in etion of cause of		
(4)	Ę	_							ormed? c	leath?	2 No		
tal Rection: The certificate ector, page		05 10/	-1			26 Diese	of Dooth /	(Check only one)	2 100 1	<b>✓</b> Yes	2 110		
of Vital ng Plysician After this cert meral directo	Be	25. Was case referred to medical examiner?	Hospital: 1 🗸 Inc		ED/O 4 15 1		Othor		1 <b>n</b>	70"			
Phys.	ပ	1 Yes 2 No			ER/Outpatient	0 0000		Nursing Home 5	Residence 6	Other:			
n of ling PI After funeral		27. Manner of Death  1 X Natural 5 Per	28a. Date of (Month, D	injury ay,Year)	28b. Time of Ir		ry at Work		how injury occurr	<b>2</b> 0			
ior fend leath tor:	atic		nding estigation			1`	Yes 2	No					
Division tal or Attendi rs after death al Director: /	ific			of Injury - At hor	me, farm, stree	et, factory, office b	uilding, etc	c. 28f. Location or Town,		er or Rural Ro	oute Number, City		
Div spital or ours afte heral Dir	Certification:		ermined (Specify)					OI YOWII,	State)				
Hosp 24 ho Func tely f			Physician: To the best of										
If It—If Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death To the Funeral Direct. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Ex	aminer: On the basis of	examination an	nd/or investigat	ion, in my opinion	, death oc	curred at the time, dat	e and place, and d	ue to the cau	ıse(s)		
To Wil	Me	29b. Signature and title of certif	and manner state	ied.		29c, Licens	e number		29d Date sign	ed (Month, D	Day, Year)		
		ALXT.				O.C.	M.E.		July 20, 20	06			
10		une			00-1			20000	1				
3		30 Name and address of perso Ana Rubio MD. As	n who completed cause sistant Medical Ex			treet Raltimo	ore MD	21201					
^_				istrar's Signatur			J.C, IVID						
S Regis	tate		2006	onal s orginally	100	EL.							

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1955 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER MERCY MEDICAL BALTIHORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-22-6315 1□M 2 F Director 06/15/1925 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at RANDALLSTOWN 1 ☐ Yes 2 No PALTIMORE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21133 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married SpeciAfrican-Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 □ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lorman House 12th Barmaid 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Leona Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8940 Harkate Way, Randallstown, MD 21133 Harvey Harris/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 iment of F tant; if it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: if any injury or once. Garrison Forest 8/14/06 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie F/H P.A. of Balt. Co 9200 Liberty Rd., Randallstown, MD 21133 232 P. III. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SOUTHMOUS CELL CHRCINOMIT OF Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai use as the signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive Chronic Yes 2 No 3 Probably 4 Unknown oral intections 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes → Wo 24a. Was an page 2 autopsy performed? To the Hospital or Attanding Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending within 24 hours after death. To the Funerel Director: Accident Accident 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai To the Fund completely f (Check only 29b. Signature and AM 2556996M225 ho completed cause of death (Item 23a) (Type, Print) 300 St. Paul 11, WHITHER M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Benjamin H. Beckwith, Jr. SEPTEMBER 05.2006 09:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 13, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 79 Yrs. Maryland Director 220-12-8684 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rsi', or items 23a or 28a-f show Examinar must be notified at 1 Yes 2 No Directo MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 Southerly Road 21286 USA Apt. 1201 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by WWII white 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Bayer Paper Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be nent of Health and Mental is marked Benjamin H. Beckwith, Sr. Emily A. Lang 19a. Informant's Name/Relationship (Type, Print) brother - 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a J. Robert Ball, M.D. / in-law 33 Marshall Rd.; Rehoboth Beach, DE 19971 permit. Pages 1 end:
Department of Health
important: if itsm 27
any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 Other (Specify)

21. Signature of Fun ra S in ice in en see Baltimore Cemetery 9/11/06 Baltimore, MD 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED INTERSTITIAL LUNG DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC ATRIAL FIBRILLATION 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an autopsy perfor certificate SEVERE PULMONARY HYPERTENSION 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Dutpatient 3 DOA this Director: After the 27. Manner of Death
1 X Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time date and place and due to the nause(s) and closurer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9-5-06 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BOON P LIM,

31. Date filed (Month, Day, Year)

M. D

TO BOOK

32. Registrar's Signature

7601 OSLER DRIVE TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene UU6

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death ent's Name (First, Middle, Last) Year **Physician** Drowr 10:30A 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 9841 Quiet Brook Clinton prince councer If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□ F Yrs 577-38-3157 77 Director 06/05/1929 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Clinton tXXYes 2 □ No PG Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9841 Quiet Brook Lane 20735 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be intentional be intentional Mental and Mental ant: If item 27 is marked o Florence Holton Joseph Bowlding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7700 Allentown Farm Ct. Ft. Washington, MD 20744 Milton Collins - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ö permit. Page Department o Important: If any injury or once. Donation 5 ☐ Other (Specify) Washington Nat'l Cem. 09/01/2006 Suitland, Maryland of Feneral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Riverdale, MD 20737
Freeman Funeral Services 5501 Cleveland Avenue Part1. En the disease, or com shock, or heart failure. List only caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CARCINOMA Immediate Cause (Final C **Physician** 3 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 No 3 Probably 4 Unknown 1 TYes Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has page 2 1 Yes Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2X No Residence 6 □Other (Specify) 1 Tyes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manner of Death After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Diractor... filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Dater signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

LTA GUPTA MD 8926 WODDYARD ROAD # 201, CLINTON ND 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [6] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar 0404 AM **Physician** Ernest 2006 Aug /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hosp ital Howard olumbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1√□M 2□F 330-01-6688 90 12-9-1915 Minnésota **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rai', or items 23a or 28a-f ehow Exeminer must be notified at 1 Yes 2 No Columbia Howard Director Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 54 Vantage Point Rd Apt. 916 filed within 72 hours atter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1943~1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ð 3 Nidowed 4 Divorced the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United States Government Pilot permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any lighty or other traumatic event SDRs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Paulson 2 Eenest L Burdge SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3355 Spartina Ave Merritt Island FL 32953 Geoffrey Burdge/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State Arlington National Cemetery 10/26/2006 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Si vallura / Funeral Service Licensee 22. Name and Address of Facility Moun & Well. Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) years **Physician** Coronary /Medical Due to (or as a consequence of): Examiner Sacuable y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by prostate cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 1 Tes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Atter this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation s efter death tilled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hickory, Ridge Rd, Columbia, 10780

State Registrar 31. Date filed (Month, Day, Year) 1

2005 32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh 8859 9-11-06 vt. State of Maryland / Department of Health and Mental Hygiene 066 28641 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Bolden Kichard Le 09 6 pm 02 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Bartimone Samaritan Hospital NIA 5. Social Security Number 7. Age (In yrs. last birthday) Il Under 1 Year | If Under Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1**℃**M 2□ F 63 Yrs. 267.86.3560 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other trsumatic svent, the Medical Examiner must be notified at N/A Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5309 Road Apt. 21239 238 eith USA Funeral Itsms 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours afte Department of Heath and Mental Hygens in filem 27 is marked other than "naturel", or I fimportant: If Item 27 is marked other than "naturel", or I sny injury or other traumatic svent, i.e. the sice Examples. 1 Yes 2 No Black ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor untion St years 12th grade 17. Father's Name irst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Bertha. bolden. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relation p (Type, Print) Bolden Creek Drive N Jacksonville FL 1239 Bertha M. Mother urtle Baltimore, 20b. Place of Disposition (Name of unk Date 20a. Method of Disposition 20c Location - City or Town, State FL. cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address Bacility Euneral Services 105 York Koad Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Massive STroke /Medical Due to (or as a consequence of): Examiner e browscular f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner rsician and (c) The law requires that the death certificate be executed ertensive the attending physician and hed for use as the burial-tran resulting in death) Last Due or as a consequence of): Box 68760 Physician/Medical al-seese use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 3 Probably 4 Unknown 1 Yes 2 VAO Completed PUBION 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 2 1No 1 Yes 2112 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Unipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 2 ER/Outpatient 3 DOA this. 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? After t Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Phatural 5 Pending Injury 24 hours after death, Funerel Director: A М 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 03 KES 000 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NABILIZEINEH LOCH RAVEN BLUD. BALTIMORE , 5601 32. Radshar's Signatur 31. Date filed (Month, Day, Year)

Registrar

RICHAR

2006

				1 - State Registrar	State of Maryland	Certificate of Death	Reg. I		28642
		Physici /Medio		1. Decedent's Name (First, Middle, L	John Brown	1 JR	2. Date of Death	- 06 Year	3. Time of Death
•	1	Examin		4a. Facility Name (If not institution, g Joseph Rit	chie Hospic		re	4c. County of Death	
	ı	Funeral Director		5. Social Security Number 219-32-9279 Usual Residence of Decedent	Sex 1 ★ 2 F 7. Age 6 7 / 7. Age 6 7	Yrs. Months Days Hours Min		ar) 9. Birthp Cour	place (State or Foreign htry)
		the Maryland 28a-f ahow notified at	tor	10a. State 10b. County	10c. City,	Town or Location		1	l Od. Inside City Limits
		ath with the Maryla 23e or 28e-f ehov	<b>Funeral Director</b>	10e. Street and Number	- Zoad	10f. Zip Code 2/2/2	10g. (	Citizen of What Cour	ntry?
	920	ours after dea alt, or Itama Exactiner ro	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Stres 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Solid Hispanic Origin? (Solid Hispanic Origin?) 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: B	
	21215-0036	vithin 72 ho ne. han "natur	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Decupation (Give kind of work done during most of wo life DO NOT use retired)	orking 16b.	. Kind of Business/In	dustry
		be filed tal Hygi d other avent, t	Be	17. Father's Name (First, Middle, Lat	<b>C</b> O	18. Mother's Na	me (First, Middle, Maid	ien Sumame)	<del>/ - (</del>
0	Maryland	12 should to and Ment	္ရ	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip	Code)
10/	altimore, I	@ ° = 5		20a. Method of Disposition  Disposition  Comparison 3	☐Removal from State	se of Disposition (Name of etery, crematory or other place)	Date Date 20c.	Location - City or To	2/206 own, State
8/31,	Baltin	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		ame and Address of Facility		neral =	ervias
	1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death.	1 carcinome o	Rol - Ral +c c or naciratory arrest,	MD 2/2	Approxima Interval By wen
34	68760,	tificate be executed by physicien and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)				
Recorn	.O. Box 68	The law requires that the death certifical sie hes been signed by the ettending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deaf 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
to	rds, F	aw requires the	þ	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the	
net	I Records	The law requisete hes been page 2 should	Completed				24a. Was an autopsy performed 1 Yes 2	? death?	psy findings available mpletion of cause of
Ama	of Vital	hysician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No		VOutpatient 3 DDA Other: 4 Nursing I	ath (Check only one) Home 5 Residence		Harace
$\Diamond$	Division o	To the Hospital or Atlending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manne of Death  1 Platural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	(Month, Day Year)	Bb. Time of Injury at Work?  M 1 Yes 2 No e, farm, street, factory, office	28d. Describe how in 28f. Location (Street City or Town, St.	and Number or Rura	al Route Number,
	Q	lospital of thours af thours af unerel D	ledical Cer	(Uneck only 2) Madical Ex	Physician: To the best of my knowle	adge, death occurred at the time, date and plac a and/or investigation, in my opinion, death occ	e, and due to the cause	i(s) and manner as s	tated.
_		To tha by within 24	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month)	1
		V		30. Name and address of person wh	o completed cause of death (Item 2	3a (Type, Print)	1 3411		901010
		Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signatur	MORE WOVE THE	YMTU	) [1][]	W/VO
						A STATE OF THE STA			

State of Maryland / Department of Health and Mental Hygiene 200528643 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician George M. Brown 7:00 P 31, 2006 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Ctr. Baltimore Co. Dundalk

If Under 1 Year | If Under If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F 217-22-0982 Yrs. Director 82 March 9, 1924 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or fems 23a or 28a-f show traumatic event, the Madical Examiner must be motified at 1 Yes 2 100 Director Eastwood Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 United States 7009 Bank Street Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural; or Items 23. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Dependant N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Nicholas Brown Margaret Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millsboro, DE Kimberlee V. Barbour (Niece) 223 Westbourne Way 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 □ Donation 5 ☑ Other (Specify) Sacred Ht. of Jesus Cem. 9/8/2006 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each limit. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events ettending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Feath Check only one Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 🗀 Inpatient 2 □ FR/Outpatient 3 □ DOA this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 atural 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature (death stem 234) (Type Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		·	1 - State of Maryland /	Dep		<b>ealth</b> a		ental Hygi	•	28644	
			Decedent's Name (First, Middle, Last)				1 2	2. Date of Death	n	3. Time of Death	
	Physicia /Medic		Marie Annie Custis					Sept.	1 2006	9;40a.M	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	f Death		4c. County of Dea	th	
	1. 2		Continuum Care at Sykesville		Sykesy				Carrol		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,			
	Director		21.4 - 22 - 1539   1   M 2   M 83					10-2-	1922   M	aryland	
	yland		10a. State 10b. County 10c. City, Tot							10d. Inside City Limits	
	Ba-f s	ctor	MD Carroll Mar	rio	tsville					1 □ Yes 2 No	
	or 28	Dire	10e. Street and Number		10f. Zip Code			10	g. Citizen of What C	ountry?	
	a 23a	Funeral Director	2417 Snowden Creek Road	10	2110		in? (Case	du Vac as No	USA 14. Race - Am	niona Indian	
	Itam Itam	un-	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	13.	Was Decedent of His If Yes, specify Cubar	n, Mexican,	, Puerto R	ican, etc.)	Black, Whi	te, etc.	
936	urs af	by	3 ☐ Widowed 4 ☒ Divorced Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify:	African- erican	
21215-0036	n 72 hours after death with the Maryland "natural", or Itama 23s or 28s-f show office! Executer transit be putified at	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Dece	dent's Usual Occupa	ition	of working	7	16b. Kind of Business		
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and	d be t	Be c						obinson	,		
Maryland	should nd Me mark matk	으	Raymond H. Custis  19a. Informant's Name/Relationship (Type, Print)  19	b. Maili					City or Town, State,	Zip Code)	
	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 Ia marked othe other traumatic avant,	4	1.1.1.		-				ville, M		
re,	of Head	1	20a Method of Disposition 20b. Place	of Dispo	osition (Name of matory or other place	3) 1 0	Da	te 2	20c. Location - City or		
Ē	Pages nent of ant: If it ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Meth	i be	malpry or other place FEY Unit hurch	ed 9	78/0	)6 1	Marriots	ville, MD	
Baltimore,	permit. Page Department Important: If any Injury o		21. Signatur Trineral School Light See							Balto. Co. , MD 21133	
	# <sup>2</sup>		23. Part f. Enter the disease of inplications that caused the death. Do	not en	ter the mode of dying	, such as	cardiac or	respiratory arre	est,	Approximate Interval Between	
	Physician	1	Immediate Cause (Final disease or condition	A						Onset and Death	
唐	/Medical Examiner		resulting in death)  Due to (or as a consequence	of):							
gr.	Examine,	<u>_</u>	Sequentially list conditions, france leading to immediate b. Due to (or as) consistence	na	£79						
<i>b</i> _	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	01).	ALA	1	56	nella	601		
,	ite be executed ysician and ne burial-transit	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence	of):	111101	m	( )	7411-1	11117		
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68	rtifica ng ph as th	led	IF FEMALE.								
Вох	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat	th 3[	Ectopic pregnancy				23d. Date of de Month	livery Day Year	
O.	0 0 0	slcl	1   Yes 2   No 9   Unknown	5[	Other (specify)				MORE	Day 18a	
<u>α</u>	that the	Ph	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	n in Part I.		23e. Did tob	acco use contribute t	o the cause of death?	
of Vital Records,	signe of be	d by	•		,.,,.,					robably 4 Dunknown	
cor	w requii been s should	Completed						24a. Was ar	24h Were a	utopsy findings available	
Re	0 4 0	dmo						autopsy	prior to death?	completion of cause of	
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical			26. Place	of Death	1 Yes 2		s 2 No	
Ž	S with	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/C	Outpatie	nt 3 DOA Othe	1 4 LUM	sing Hom	e 5 🗆 Reside	nce 6 Other (Spe	ecify)	
0 4	ding Phi h. After thi funeral		27. Manne eath 1	Time o	f 28c. Injury Work	at ?	28	3d. Describe ho	w injury occurred		
Sio	Attending ir death. actor: After by the fune	catle	2 Accident investigation			′es 2□N	No				
Division	tel or Att rs after d al Diract ed in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	farm, st	reet, factory, office		28	3f. Location (Str City or Town	reet and Number or R , State)	lural Route Number,	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge one)  1 Medical Examiner: On the basis of examination a and manner stated.	ge, deat and/or in	h occurred at the time vestigation, in my op	e, date and inion, deat	d place, ar th occurred	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
)	To the within 2 To the complet	M	29b. Signature and where consider Cheva	MI	29c. License	0 5 0 5	42	18	9-1-2 Wentu	2006	
	4		30. Name and address of person who completed cause of death (Item 23a	(Type	Print) 349 Ma	lea	Im c	luke,	Westin	inter MI)	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1						21157	
	Registr	ar	SFP 1 1 2006	fine.	marks.					ĺ	
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			For State Registrar	State of Man	yland / Depa	artment of H	lealth a		ntal Hygie	ene . No. 200	28645
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last  Donal Louis  4a. Facility Name (If not institution, give	Clabaugh	)	4b. City, Town, o	r Location of		Date of Death Month	Day Year 7 200 4c. County of De	6 1 :30 A M
	Funeral Director		30 South Hawthorne 5. Social Security Number 6. Se	Road	In yrs. last birthday) 74 Yrs.	Middle If Under 1 Year Months Days	River If Under 2	4 Hrs. 8 Min.	Date of Birth (Month, Day.)	Baltimon (ear) 9. E 931 Pen	Ce State or Foreign Country) nnsylvania
	Marylend -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		oc. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2☐No
	seth with the a 23a or 28s must be not	Jirec	10e. Street and Number 30 South Hawthorne	Road  12. Was Decedent Eve	orin II C 13 1	10f. Zip Code 21220		in? /Specif		U.S.A.	Country?
900	within 72 hours after deeth with the Marylend ene. Than "natural", or itema 23a or 28a-f ehow ite Medical Examinar must be notified at	<u></u>	11. Marital Status  1 □ Never Married 2 ☑ ★ arried  3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1952-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Puèrto Rio		Specify: Tobb. Kind of Busine	White
Maryland 21215-0036	be filed within 72 hours after deeth with the Marylen ital Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most			teel Man	ıfacturer
aryland	should be filed ind Mental Hygi marked other umatic event, I	0	17. Father's Name (First, Middle, Last) Walter Clabaugh  19a. Informant's Name/Relationship (7)	ype, Print)		ng Address (Street	Doroth	hy St	ineman Route Number,	City or Town, State	
	s 1 end 2 of Heelth a Item 27 is other tra		Marguerite Clabaug  20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Dat	e 2	Oc. Location - City	ryland 21220 orTown, State , Maryland
Baltimore,	permit. Pege Depertment of Important: If eny Injury or	2	21. Signature of Funeral Service Licen	580	23	2. Name and Addre Br 1407 Old	uzdzii Eastei	hski rn Av	Funeral enue, E	Home, P ssex, Ma:	
E	Pnysician /Medical		23a. Part1. Erier the disease, or compshock, or heart failure. List only disease or condition resulting in death)	. Squar	nous cel	cancer of	of Val	lleak	Cespiratory arres	it.	Interval Between Onset and Death
760,	tte be executed wysiclen and which transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a c	consequence of):						
Box 68	The law requires thet the deeth certificete to the seem signed by the ettending physicape 2 should be detached for use as the base.	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	☐Fetal death 3	□Ectopic pregnanc;	у			23d. Date of Month	delivery Day Year
ords, P.O.	w requires thet to be the signed by should be detailed.		Part II. Other significant conditions o	ontributing to death but	not resulting in the t	anderlying cause giv	ven in Part I.				e to the cause of death?  Probably 4 □Unknown
of Vital Records,	sician: The law r certificete hes be irector, page 2 sh	e Completed by	25. Was case referred to medical				26. Place	of Death (	24a. Was an autopsy perform 1 Yes 2	ed? prior death No 1 □ Y	autopsy findings available to completion of cause of ??
on of Vi	g Physe ter this nerel di	P B	examiner?  1  Yes 25 No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day)	2 ER/Outpatie 28b. Time o Injury	of 28c. Injui	ry at	28		nce 6 □Other (S v injury occurred	(pecify)
Division	Ital or Atten	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc.					City or Town,	State)	Rural Route Number,
	To the Hospital or Attendin within 24 hours effer death. To the Funaral Director: Af completely filled in by the fur	Medicai	29a. Certifier 153 Certifying Ph (Check only 2 Medical Examone)  29b. Signature and title of certifier	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	29c. Licens	opinion, deat se number	th occurred	1 at the time, da	te and place, and o	due to the cause(s)
	141		30. Name and address of person who		uth (Item 23a) (Type	Print)	3635	13 n	althmor	9/8/	212-1
5	St Regist	ate rar	31. Date filed (Month, Day, Year)	arshall BV 32. Registrar 06	s Signature	and order	reu II		all mor	e, / \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	401

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fb 9870 8-10-07 vt

State of Maryland Department of Health and Mental Hygiene 2 0 0 6

28646 Certificate of Death Reg. No. 2 Date of Death Decedent's Name (First, Middle, Last) Day **Physician** September 1, 2006 10:48p M Delois Cutter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Gilchrist Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6442 8. Date of Birth April 6,1953 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗓 F 53 Yrs. Arkansas Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be natified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Towson 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 6601 North Charles Street 21201 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner/Laborer Computer Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wallace Cutter Minnie McCullough 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8667 Winands Road Randallstown, MD 21133 Charlotte Burton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lott Burgy Cemetery El Dorado, AR 9-6-06 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Upenser 22. Name and Address of Facility Andrews Funeral Home Klliberry 1211 East Main Street, Eldorado, AR 71730 Loann Approximate Interval Between Onset and Death 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ancu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a cons y uence of : Examiner be detached for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 No 1 Yes 1 TYAS A ter this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 AOther (Specify) NOSDIO 1 ☐ Yes 2 No ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST BARMORE MD LIZZE AMOIN Je 6601 M LHMURS 31. Date filed (Month, Day, Year) SFP 1 1 2006 32 Registrar's Signature State goods Registrar

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	Dhysisia		Decedent's Name (First, Middle, Last)				<ol><li>Date of Death Month</li></ol>	Day Yea	
	Physicia /Medic		Ulfat Rai Chopra				Sept.	8 200	
	Examin	er	4a. Fecility Name (If not institution, give street 406 Firestone Drive	and number)	4b. City, Town, or Locati			Montgo	
2.	F1		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Un	nder 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign Country)
	Funeral Director		217-02-2402 XDM 2	□ F 77 Yrs.	Months Days Hou		Month, Day, Jan. 13	1929	India
	p. ,		Usual Residence of Decedent	10c. City, Town or Lo	position				10d. Inside City Limits
	arylar show	2	10a, State 10b, County		er Spring				1 ☐ Yes 2∑ No
	the M	ect	Maryland   Montgomery	PIIV	10f. Zip Code		10	ng, Citizen of What	Country?
	3a or	0	406 Firestone Drive		209	05		Indi	a
	within 72 hours after death with the Maryland ene. then "netural", or itema 23a or 28a-f show the McJical Exertinet inust be motified at	Funeral Directo	11 Marital Status 12. W	as Decedent Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Spec	ofy Yes or No-	14. Race - A Black, W	merican Indian,
٥	after or Ite		lf '	TYPS 2 NO	1 ☐ Yes X☐ No Spec			Canaiba	
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7 7	yiene.	mo	Elementary/Secondary (0-12) Co	ollege (1-4or 5+) 4	Accounta	int		Accoun	ting
ğ	al Hyg	BeC	17. Father's Name (First, Middle, Last)		18. M	fother's Name	(First, Middle, M	Maiden Surname)	
<u>X</u>	12 should be filed within ? n and Mental Hygiene. r is marked othar then " r raumatic event, the Med	10	Ramsaran Das Chopr				Devi Pu		7: 0:41
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Pi		ng Address (Street and Nu irestone Dri				
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or Itema 23a or 28a-f show item 27 is marked other then "natural", or Item in all be notified at other traumatic event, the Medical Exarcificat install be notified at		Vippan Chopra/son  20a. Method of Disposition	20b. Place of Dispe	osition (Name of	Da	ate 2	20c. Location - City	
20	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	matory`or other place) .del Cremator	Sept	2006	Odenton,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra-		21. Signature of Funeral Service Licensee	1)0	2. Name and Address of Fanaldson Fune	acility			
ш	205 29	U I	23a. Part1. Enter the disease, or complication		naldson Fune II Annapolis				Approximate
8760,	Physician Medical Examiner  Short of the physician and phy	dical Examiner	Sequentially list conditions, b. lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	iosclerotic	Cardio	vascula	r Disease	Onset and Death
O. Box 6	the death certifi y the attending iched for use as	Physiclan/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
S, D	es tha gned be de	by	Part II. Other significant conditions contribut Non-Insulin Dependent	-		Part I.			e to the cause of death?  Probably 4 □Unknown
orc	w require been si should I	Completed	Non-Insulin Dependen	it brabetes near			24a. Was a		autopsy findings available
Sec	has b	du					autops	y prior	to completion of cause of h?
<u> </u>			25. Was case referred to medical		26 F	Place of Death	(Check only on		Yes 211 No
5	Physician: r this certific ral director,	o Be	examiner?  1 Yes X No	al: 1   Inpatient 2   ER/Outpatie	Othor		One of the latest and the	ence 6 Other (	Specify)
n of	ding Ph h. After thi funeral	lon; T	1X□Natural 5 □ Pending	a. Date of Injury 28b. Time ( (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes		8d. Describe ho	ow injury occurred	
Division of Vital Records,	Attan r deat ector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	reet and Number on, State)	r Rural Route Number,				
_	Hospita 4 hours Funeral ely filled	edical Ce	(Check only 2 Medical Examiner: 0	n: To the best of my knowledge, dea On the basis of examination and/or i	th occurred at the time, dat	ite and place, a	and due to the ca	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the h within 24 To the f complete	Med	29b. Signature and title of certifier	and manner stated	29c. License num	nber	2	9d. Date signed (N	fonth, Day, Year)
	F 3 F 3		1 / / / VI II III	DROLLOIN	D1689	97		September	8, 2006
	77		30. Name an a dress of person who comple	ited cause of death (Item 23a)	1				
_	muse <sup>2</sup> p <sup>nb</sup>		William Rosson 570	85th Ave. New (		MD 207	84		
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 1 2006	32. Registrar's Signature	sale)				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Frances Riley Carson 2006 28648 Certificate of Death Reg. No Date of Death Registrar 1. Decedent's Name (First, Middle, Last) Month 0857 hrs Physician/ August 31, 2006 CARSON **Medical Examiner** ANNE **FRANCES** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Laurel 7008 Red Miles Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Pennsylvania 5/16/1935 Director 2 x F 71 1 M 579-46-7932 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 No Laurel 28a-f shov s 23a or 28a-f show notified at once. Maryland Prince Georges 10g. Citizen of What Country hours after death with the Maryland Director 10f Zip Code 10e. Street and Number United States America 20707 7008 Redmiles RD 14. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status White etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married 2 1 X Yes Specify: White If Yes, Give Year 1951-1954 or Dates Yes 2 X No specify. Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ۵ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) than the Medical 21215-0036 Own Home should be filed within and Mental Hygiene Homemaker 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Sharp item 27 is marked æ Francis Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Pages 1 and 2 should rent of Health and Mer Laurel 20707 7008 Redmiles Rd S Daniel Carson/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a Method of Disposition

1 Burial 2 Cremation 3 Removal from State crematory or other place) Baltimore, Catonsville, Maryland 9/8/2006 Metro Crematory mportant: Donalion 5 Other Specify 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Fleck Funeral Home 7601 Sandy Spring Rd Laurel, MD 20707 Mille 4 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death /Medical a Cardiac tamponade Immediate Cause (Final disease ⊊xaminer or condition resulting in death) Due to (or as a consequence of): b. Ruptured aortic dissection Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate c. Hypertensive Atherosclerotic Cardiovascular Disease cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical AMENDED tending physician a UNPENDED 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 attending past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? the P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ Metastatic esophageal carcinoma 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of should autopsy performed? death? 1 🗸 Yes Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Other<sub>4</sub> Division of Vital Be Nursing Home 5 Residence 6 Other: Scene Hospital: 1 examiner? DOA Inpatient 2 ER/Outpatient 3 this 2 No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 1 27. Manner of Death 1 Yes 2 No 1 V Natural Pending Director: 24 hours after death. 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be 3 (Specify) To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 1, 2006 O.C.M.E. 30 Name and address of person who completed cause of death (Item 23a) 10 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

State

Registrar

31. Date filed (Month, Day, Year)

1 200 32. Registrar's Signature

Mill of Superior

The Street

State of Maryland / Department of Health and Mental Hygiene 2005 28649 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 0520 A M Dicus 2006 reta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hady Grove Adventust Hospi Rockville Montgomery 8. Date of Birth (Month, Day, Year) Nov 23, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Min Months Days Hours 1□M 2√2F 432-68-3128 66 1939 Hot Springs, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County worle 27 is marked other than "natural", or itame 23a or 28a-f shov traumatic event, the Medical Examt, ar must be rediffed at 1 ☐ Yes 2 No Poolesville Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18505 McKernon Way 20837 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Physicist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked other Jessie Carle Dicus, Sr. Rhada Pauline Castle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kevin Gentry (Nephew) 106 Sunset Bay Road Hot Springs, AR 71913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Hollywood Cemetery 9/7/06 Hot Springs, AR 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility
Caruth-Hale Funeral Home 155 Section Line Road Hot Springs, AR Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bleed **Physician** /Medical Due to (or as a consequence of) Examiner HB encepulopathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunkhown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has t firector, page 2 s 1 Tyes 2 Nd Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Sich After the 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD YYAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

RIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2 Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) SEPTEMBER 8,2006 8:00 P. M Physician FRANCES Τ. Del Buono /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **PROVIDENCE** ROAD TOWSON BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-18-1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** WEST VIRGINIA Months Days Hours 1 M 2/X 83 Vrs 235-38-8603 Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. County Worle r then "neturel", or items 23a or 28e-f ehor the Medical Examiner must be notified at 1 Yes X No Director BALTIMORE TOWSON MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 PROVIDENCE ROAD 21286 U. S. A. death y Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specity: WHITE Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) YEARS Elementary/Secondary (0-12) OWN HOME HOUSEWIFE permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: if Item 27 is marked ofth any lighty or other traumatic event, SING. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HOPKINS DORA FRANK DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SUZANNE F. CLULOW (DAUGHTER) 714 PROVIDENCE ROAD, TOWSON, MARYLAND, 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2(Cremation 3 Removal from State 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 09-12-2006 TOWSON, MARYLAND, 21204 1050 YORK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. W. Ru RUCK TOWSON FUNERAL HOME, INC. (.G.RUTH) TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) 5-101 Priysician month /Medical Due to (fr as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of). Examiner the attending physicien and P The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2**XX**(No 1 TYes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Yes ¾ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide XX. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauca(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 11, 2006 10 01658 20 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 056 110002 31. Date filed (Month, Day, Vear) 32. Registrar's Signature State SEP 1 1 2006 Registrar

		1	State of Maryland / Department of Health and Certificate of Death	l Mental Hyg	giene 200 8	28651
2	Physicia	an	1. Decedent's Name (First, Middle, Last) Eileen S. Dezell	2. Date of Dea Month Septembe	er 9, 2006	3. Time of Death 4:45 A M
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Oak Crest Village Care Center  4b. City, Town, or Location of De	ath	4c. County of De Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Days 8. Hours 9. Min		<sup>9. B</sup> 1928	irthplace (State or Foreign Country) New York
- 25	show	or.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Marvland Baltimore Parkville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N 3s or 28a-1	Funeral Directo	Maryland Baltimore Parkville  10e. Street and Number 10f. Zip Code 21234		10g. Citizen of What (	Country?
36	J within 72 hours after death with the Maryland jiene. Than "natural", or Items 23s or 28s-f show the Musical Examination notified at	by Funera	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:  1 □ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. White
Maryland 21215-0036	within 72 hou ene. than "natura he Medical E	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of with DO NOT use retired)  Guidance Counselor		16b. Kind of Busines Baltimore Dept. of E	County
and 21	be filed tal Hyg od othe event.	Be	17. Father's Name (First, Middle, Last)  18. Mother's N	Name (First, Middle, Reilly		audation
	nd 2 shoulth and 27 is m	To	19a. Informant's Name/Relationship (Type, Print)  Thomas R. Dezell / son  19b. Mailing Address (Street and Number or 104 Regent Drive; Be			, Zip Code)
Baltimore,	# O .			.3/06	Eastcheste	er, NY
Ball	permit. Page Depertment of Important: If any Injury or		21. Signature of Funeral Service, Licensee  22. Name and Address of Facility  Ruck Towson Funeral		Towson,	MD 21204
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only ofe cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a		rest,	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and car for use as the burial-transit	edical Examiner	Sequentially list conditions.  It all, leading to introduct or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
P.O. Box 68	Q 0 Q	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   Unknown   5   Other (specify)   1   Control of the past 12 morths?		23d. Date of o Month	delivery Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4 □Unknown
of Vital Records,	Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be detached.	Completed		24a. Was autor period 1 Yes	osy prior to death	autopsy findings available to completion of cause of ? es 2 3 No
/ita	ysician: Th is certificate director, pag	Be	examiner?	Death (Check only o	-	
of	Phys rthis ral dir	- To	To inpatient 2 EP/Outpatient 3 DOA 4 Minutesin		dence 6 Other (S	pecify)
o	Attending I r death. ector: After by the funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No			
Division	al or Atters s after dea	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or Tot	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o and manner stated.		date and place, and o	flue to the cause(s)
)	To t To t	×	29b. Signature and title of certifier  29c. License number  1) 5 8 6 4	6	September	
220	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Anna Monius 5500 Walther Boulevase)	Parl	wille, un	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 1 2006			

Eileen S. Dezell 9/9106 4:45 AM

State of Maryland / Department of Health and Mental Hygiene 2006 28652 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:25 P M DIGGS SEPTEMBER 6, 2006 AUHUL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CITY BALTIMORE THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Ol-1) Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 216-30-0763 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r then "natural", or Iteme 23s or 28e-f ehow 1 Nes 2 No timore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe alais Hvenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 No Iffes, Give Year or Dates: 14 Bace - American Indian Black, White, etc. Married 1 Never Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ine. DO NOT (se retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) nishe () Al Middle, Maiden Sumame Middle, Last) ss (Street and Number or Rural Route N ber, City or Town, State Baltimore, 20c. Location 20a. Method of Dispos 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signat re of Funera Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE CHRONIC OBSTRUCTIVE PULMONIMEY DISEASE 10 YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending physic 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ADDIC VALUE REPLACEMENT 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? COLONDAY METERY DISEASE s certificate hes t lirector, page 2 s 2□ No 2 No 1 Tyes HYPERTENSION Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 21 No 1 patient 6 ☐Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending To the moores efter death, within 24 hours efter death.

To the Funeral Director: After the funeral in by the funeral in by the funeral properties of the funeral fune 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 SEATTEMBER 6, 2006 - MEDEAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEWIN E. WWDS, THE JOHNS HOPKINS HOSPITOL, GOD NORTH WOLFE STREET, BAITIMONE, MD 21205 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Board,

06-06618		Please Type or Print in Black Indelible ink		
Michael D. Freei	man	State of Maryland / Department of Health and Mental Hy	/giene	2006 2061
		For State Certificate of Death	Reg.	No. 2006 2865
Physicia		1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Exami		Michael D. Freeman	Month E September	0ay 4, 2006 1221 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
( )		Sinai Hospital Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Director	- 1	Months Days Hours Min	10-28	Foreign Country) MD
	L	218-88-4076   1XM 2 F   32 Yrs.   100 No. 100	10-20	-/3 County, [·ID
<u>*</u>	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
w any				1 Yes 2 YNo
land f sho	ö	MD Baltimore Pikesville		
Mary 28a- d at	Director	10e. Street and Number 10f. Zip Code	10g	Citizen of What Country?
the a or	اة	3 Stockmill Road, Apt. A 21208		USA
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Sp		14. Race - American Indian, Black,
leath r iter	١Ĕ	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. African-
fter c	Ē	3 Widowed 4 Divorced If yes, Give Year or Dates:		African- Specify:American
urs a fura	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		6b. Kind of Business/Industry
2 ho	iş.	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life DO NOT use retir	red)	Hayes and Howell
hin 7	힐	12th Artisan		
d wit	팃	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, Ma	iden Surname)
al Hy	Be	John M. Freeman Theres	sa E. W	addell
212 ald be Ment mark	P P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R	Rural Route Numbe	er, City or Town, State, Zip Code)
shou and 7 is natio	11.			21208
md 2		20a Method of Disposition 20b Place of Disposition (Name of cemetery.	Apt. A.	PIkesville, MD  20c. Location - City or Town, State
of He		1X Burial 2 Cremation 3 Removal from State crematory or other place)		
Page nent ant:	ш	1X Burial 2 Cremation 3 Removal from State King Mem. Park 9/9	9/06	Woodlawn, MD
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	21. Signature of Unen Service Vicen 22. Name and Address of Facility Wy	lie F/H	P.A. Of Balto. Co
<b>a</b> 52 5 5	- 1	9200 Liberty Rd.	. Rand	allstown, MD 2113.
Physician		23 of or Early the Iseas or amplications that caused the death. Do not enter the mode of dying, such as cardiac or a fure. List only one cause in each line.	r respiratory arres	t, shock, or heart Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Gunshot wound of neck and chest		Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		
۹,		Conventielly list conditions b.		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	盲	cause. Enter Underlying Cause (Disease or injury that initiated		
\ <b>Q</b> = ₹	xai	events resulting in death) Last  Due to (or as a consequence of):		
executed an and all - transit	a	d		
<u>a a a</u>	i Si	UNPENDED		
Division of Vital Records, P.O. Box 68760, within 24 hours flored the horization of the physician: The law requires that the death certificate be to the funeral Birector: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	sician/Medical Examiner	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
687 ertific ding	an/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	incy	Month Day Year
eath ce attence for use	Sici	4 Pregnant at time of death 5 Other (Specify)		
B B B B B B B B B B B B B B B B B B B	Phy	a Oliviowii	-122	
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
sign lbe of		Market Market State Control of the C	1 Yes	2 No 3 Probably 4 Unknown
rds requ	ete		24a. Was an autopsy	
CO law law has e 2 sl	Completed		perform	ed? death?
Rec The Tre ficate	Ŝ		1 <b>Y</b> Yes 2	No 1 ✓ Yes 2 No
ital Fician:	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursin		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the and the death from the certificate has been signed by led in by the funeral director, page 2 should be detach	၉	Yes 2 No		esidence 6 Other.
n of ding Ph		27. Manner of Death 28a. Date of Injury 1 Natural 5 Panding Sep 4, 2006 1127 hrs 127 yes 2 ✓ No	Subject was s	w injury occurred shot
IVISION Or Attend after death Director:	atic	1 Natural 5 Pending Sep 4, 2006 1127 hrs 1 Yes 2 ✓ No		
ViS or At fter d birec	ţ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rural Route Number, City
Divinal of ours at Effled	Certification:			eights Avenue, Baltimore, MD
Divis Hospital or A 24 hours after Funeral Dire		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(	(s) and manner as started.
To the How within 24 h To the Fur	Si	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a	t the time, date an	nd place, and due to the cause(s)
To with	Medical	and manner stated  29b. Signature and title of certifier  29c. License number		29d. Date signed (Month, Day, Year)
	-	hi hi, mo O.C.M.E.		September 5, 2006
		30. Name and address of person who completed cause of death (Item 23a)		
· Y		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
	tate	31. Date filed (Month, Day, Year) 1 2006 32. Registrar's Signature		
Regis	trar	SEP I I 2000 palacion Do separa		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28655

	1- For State Registrar	Certificate of Death	Reg. No. 2000 200
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	Gruman	2. Date of Death Month Day Year August 27, 2006  3. Time of Death 2030 hrs
The state of the s	4a. Facility Name (if not institution, give street and number) 3508 Napier Street	4b. City, Town, or Location of Dea Silver Spring	th 4c. County of Death  Montgomery
Funeral Director	5. Social Security Number 107–18–6331	(In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours Mi	
th the Maryland 23a or 28a-f show any notified at once. al Director	10a. State 10b. County 1 MD Montgomery 1 10e. Street and Number 3508 Napier Street	Oc. City, Town or Location Silver Spring  10f. Zip Code 20906	10d. Inside City Limits  1 Yes 2 XNo  10g. Citizen of What Country?  USA
hours after death wi natural", or items Examiner must be ted by Funers	3 Widowed 4 Divorced III Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puering No  1 Yes 2 No specify:  16a. Decedent's Usual Decupation (Give kind or during most of working life, DO NDT use or	o Rican, etc.) White, etc.  Specify: White  work done 16b, Kind of 8usiness/Industry
215-0036 be filed within mal Hygiene riked other tha ent, the Medic ent, the Medic Be Compl	Joseph Bousley	Art Teacher  18.Mother's Nan M. Jose	Education  e (First, Middle, Maiden Surname)  phine Salloway
MD and 2 sho salth and the sem 27 is raumati	19a. Informant's Name/Relationship (Type, Print )  Harris L. Gruman (Son)  20a Method of Disposition  1 Xi Buriat 2 Cremation 3 Removal from State	242 Summer Street  20b. Place of Disposition (Name of cemetery,	Rural Route Number, City or Town, State, Zip Code)  Somerville, MA 02143  Date   20c. Location - City or Town, State
Baltimore, permit Pages 1a Department of He Important: If ite	4 Donation 5 Other Specify  21. Sights are of Funeral Service Libraries	Linebrook Cemetery 9/  22 Name and Address of Facility Whittier-Porter F	6/06 Ipswich, MA uneral Home swich, MA 01938
Physician /Medical Examiner	23a Palt Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Condition resulting in death)	ne death. Do not enter the mode of dying, such as cardiac Cardiovascular Disease	
red last	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
760, cate be executed physician and he burial - transit		quence of):	
P.O. Box 68760, s that the death certificate be execu gred by the attending physician and e detached for use as the bunal - tra by Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1	2 Fetal death 3 Ectopic preg	23d. Date of delivery  Month Day Year
cords, aw require has been sig 2 should be		but not resulting in the underlying cause given in Part 1.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown  24a. Was an autopsy performed?  1  Yes 2  No 1
Vital Rechysician: The lithis certificate lidirector, page	25 Was case referred to medical examiner? Hospital:	26.Place of Death (Chec	
Sion of \\ \text{vttending Phy} \text{death} \text{ctor: After th} y the funeral of the content of the co	27 Manner of Death 28s Date of Journ	y 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  ury - At home, farm, street, factory, office building, etc.	28d. Describe how injury occurred
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Afte completely filled in by the fune Madical Certification:	28f. Location (Street and Number or Rural Route Number, City or Town, State)  nd due to the cause(s) and manner as started.		
To the Ho within 24 To the Fu Completel	one) Medical Examiner: On the basis of examiner: On the basis of examiner and manner stated.  29b Signature and title of certifier  Multiple Multip	ination and/or investigation, in my opinion, death occurred  29c. License number  O.C.M.E.	29d Date signed (Month, Day, Year) August 28, 2006
1	30. Name and hours of person who completed cause of de Laron Locke MD. Assistant Medical Example 1.	miner 111 Penn Street, Baltimore, MD 21	201
State Registra DHMH 17 Rev 1/2001	SEP 1 1 2006	s Signature ORIGINAL	

06-0658	38
Dontira	Grant

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 2006 28656 1- For State Certificate of Death Registrar Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day September 3, 2006 Grant 0900 hrs Dontira Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Harbor Hospital If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Months Country) Mn Director Tune 21 1 M 2 F WK Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State any 1 Lyes 2 No Baltimone 28a-f show MD death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 21230 U.SK Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Armed Forces? Married Apri can Yes 2 V NO Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after of
pepartment of Health and Mental Hygiene.
Important: I fitem 27 is marked other than "natural", of
injury or other traumatic event, the Medical Examiner m 1 Yes 2 No specify Amery Can 3 Widowed Divorced Yes, Give Year ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Donta A. Grant 19a. Informant's Name/Relationship (Type, Print) ပ္ 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9/06 Mt. Zvan Com 4 Donation 5 Other Specify 21. Signature of Funeral Service Licen-Bultmore MD 21206 Approximate Interval Between Onset and 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and transi Physician/Medical ttending physician a r use as the burial -M UNPENDED **AMENDED** 27 28a-f. perME 9861 11/8/06 TT #232 Box 68760 23d. Date of delivery IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 1 Live birth 3 Ectopic pregnancy Dav Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No 1 🗸 Yes certificate ✓ Yes 2 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 27. Manner of Death Certification: To the Hospina.

within 24 hours after death

To the Funeral Director: A' 1 Natural 1 Yes 2 No Pending Fnd 9/3/2006 FNd 8:30 am unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2229 Annapolis Road 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 K Could not be Baltimore, MD 4 Homicide (Specify) found at home determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. September 4, 2006 9 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006

Registrar

SFP 1

		,	For State Registrar	State of Maryland / De	partment of Health and Nertificate of Death	lental Hygien Reg. N		28657
	Physici /Medic		1. Decedent's Name (First, Middle, Las WILLE	"EUNN		2. Date of Death Month	\/	Time of Death 9:35 PM
	Examir		4a. Facility Name (If not institution, give	street and number)  ( HOJDITAL	4b. City, Town, or Location of Death らればりかいた。ル	1031933	County of Death	
	Funeral Director		5. Social Security Number 6. Se 1) 6. Se 1)	7. Age (In yrs. last birthdo	Months Days Hours Min	8. Date of Birth Month, Day, Yea	9. Birthplace Country)	(State or Foreign
	aryland show	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or			10d. I	Inside City Limits 1 ☐ Yes 2 ☐ No
	Ne M	Director	MO N/	17 Sal	101. Zip Code	100.0	Citizen of What Country?	
	with t	Dir	10e. Street and Number 2819 W. V.	nulberry St.	Z1223	109. 0	USA.	
	death	Funerai	11. Marital Status		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American II	ndian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of the province of the than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examination must be notified at once.	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Specify: B/ac	k
ر ک	72 hc natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ing 16b.	Kind of Business/Industr	ry
2	within Bne. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired) I ron Workes	,	Step/	/
ם פ	Hygi Hygi other		17. Father's Name (First, Middle, Last)			e (First, Middle, Maide		
<u>a</u>	Aental I	To Be	Eli (90	nn	Ro.	sabell	Gunn	
ary	2 should and h	Г	19a. Informant's Name/Relationship (7		ailing Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Cod	
χ. Σ	and 2 ealth m 27 i		Arlyne Gra	1/ Daughter 2	819 W. mulbers	my St., B	not more Me	
Baltimore,	Pages 1 ment of H ant: If Ite ury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State cemetery, o	ate Com. 9/8	109 A	Location - City or Town,	ND
Dail	Departition Depart		21. Signature of Fune al Syrice Usen.	see	22. Name and Address of Eachity & E Har, P. 10> E 5126 Belain	Funera	Service.	P. A. 0 21206
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of	olications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	App	proximate erval Between set and Death
ı	Physician		Immediate Cause (Final disease or condition resulting in death)	a SEPSIS			311	
	/Medical Examiner		Toolanning in doubtry	Due to (or as a consequence of):	Δ			
١,		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	, 1			
	ud ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	r —				
Ď,	e exec ien ar irial-tr	Exe	resulting in death) Last	Due to (or as a consequence of):				
09/99	ificate be executed g physicien and as the burial-transit	edical		d				
	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day	y Year
as, r.	uires thet t signed by Id be deta	d by Ph	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the ca	ause of death?
Jivision of Vital Records,	ne law require has been sig ge 2 should t	mpiete	HTN, ARTERI DISEASE	oscienotic CARI	DIOVASCULAR	24a. Was an autopsy performed?	24b. Were autopsy: prior to comple death?	findings available ation of cause of
ē	hysicien: The law nis certificete has t I director, page 2 s	ပိ	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 🔁 N	√o 1 ☐ Yes 2 ☐	No
5	ysicie is cert direct	To B	examiner?	Hospital: 1 Inpatient 2 ☐ ER/Outpa		ome 5 Residence	6 ☐Other (Specify)	
0 00	Attending Physicien: r deeth. ector: After this certifice by the funeral director; p		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time	e of 28c. Injury at	28d. Describe how in		
DINIS	al or Atter after decided in Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, larm, building, etc. (Specify)	street, factory, office	281. Location (Street City or Town, Sta	and Number or Rural Ro ate)	ute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowledge, di iner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	1. cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2001-hol. m.n	29c. License number	29d. C	Date signed (Month, Day,	Year)
	1		I Jonet U- n	rophibeli, m.D.	D14949	191	3 2006	
			30. Name and address of person who of JANET V - WOLH	completed cause of death (Item 23a) (Typ MEU, MD )	pe, Print)  TO W. BALTIMONE	ST., BALT	imune, m.	021273
	Sta Registi		31. Date liled (Month, Day, Year) SEP 1 1 20	32. Régistrar's Signature	Goods.	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) th Year Month Day **Physician** SEPTEMBER 08 2006 GUINAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Center Baltimore Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May 1 9, 1929 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2XX 77 217-24-1817 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XXNo MD Baltimore Owings Mills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 500 Hammershire Rd. 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: or items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married 1 Yes XXNo Baltimore, Maryland 21215-0036 Specify: Specify: White δ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott Be Alvin Phillips Florence Rodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 500 Hammershire Rd. Owings Mills, MD 21117 Leo. E. Guinan / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other Baltimore XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or once. 4 ☐ Donation 5 1 Other (Specify) 9/12/06 Baltimore, MD National Cemetery 21. Signature of Fundral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** RUPTURE ABDOMINAL AORTIC /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of MRTER! Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and d be detached for use as the burial-transit HRONIC OBSTRUCTIVE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Kunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an this certificate has autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of De ath 28b. Time of 28d. Describe how injury occurred Certification: al or Attending P safter death. i Director: After I d in by the funera 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di 1td Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number rella m.o 41410 SEPTEMBERO8 200 30. Name and address if person who completed cause of death (Item 23a) (Type, Print) JOGINDER RANDALISTOWN MO

Registrar

2006 SEP 1 1

MOATHWEST 31. Date filed (Month, Day, Year)



		_	For State	State of Marylan		nent of Health and cate of Death		iene 2006	28659
			Ragistrar  1. Decedent's Name (First, Middle, Last	"			2. Date of Deat	h	3. Time of Death
	Physicia	an	WENDELL G	3000200	Mari		Geptembe.	Day Year	2:30 AM
	/Medic		4a. Facility Name (If not institution, give	street and number)	4b.	City Town, or Location of De		4c. County of Death	
н	Examin	er	FRANKLIN Square	Medical Ce	nel ,	BAHAMORE		4/4	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday) If	Inder 1 Year If Under 24 H	Irs. 8. Date of Birth (Month, Day,	Year) 9. Birthpla	ace (State or Foreign
	Director	Į	219-14-0331	×M 2□F 46	Yrs.		December	19 1959 MAR	24/And
	pu k	-	Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Locatio	n		10	d. Inside City Limits
	sho	ō	Hazel 1 Was		Himok				1 AYes 2 No
	the A	Director	10e. Street and Number	101		Y. Zip Code	1	0g. Citizen of What Count	ry?
	with		207 lundly	-1 street		21219		USA	
	leath	Funerai	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Was	Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - America	
(0	r Iter	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		i, specify Cuban, Mexican, Pu ∕es 2 <b>⊠</b> No <i>Specify:</i>	ierto Rican, etc.)	Black, White, e	
215-0036	72 hours after death with the Maryland naturel: or Items 23e or 28e-f show alcal Exercitive Coust by notified at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		es zpadno spacity.		1111-01	MERICAN
5-0	72 h	etec	15. Decedent's Edi (Specify only highest grad		16a. Decedent's (Give kind	S Usual Occupation of work done during most of s IOT use retired)	working	16b. Kind of Business/Ind	ustry
121	within ene. than "i	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		able		2/14	
121	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)				Name (First, Middle, i	Maiden Sumame)	
Maryland	d tal	o Be	OTIS HALL			Flo	cine :	Smith	
<u>-</u>	2 should and Men is marke eumatic	은	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Ad	Idress (Street and Number or		City or Town, State, Zip	Code) /2/23
N	and 2 salth ar n 27 is		Florine HAM	(Mother)	8271	undhurst:	steet B	Altimoke, M	DARGHAMI
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition	1 -	Place of Disposition	(Name of v or other place)	/	20c. Location - City or Tov	vn, State
Ë	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donatjon 5 ☐ Other (Specify	Removal from State	meteo.	remataly sep	4.12,200	BAHAMSKE	Altry Stand
altimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	S98	22. Na	me and Address of Facility	C	). Franklin	Strateliza
m	8 8 8 8		puley m. Ce	allare	LAL	Ry M. Cerallace	e FURERA	e service	BALLIKE
			23a. Part1. Enter the disease, or composition, or heart failure. List only of	lications that ceused the deat one cause on each line.	h. Do not enter th	e mode of dying, such as card	diac or respiratory arr	-11	Approximate Interval Between Onset and Death
1	Physician	8 4	Immediate Cause (Final disease or condition	· multiple	Melon	17.	ory to	breakween	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	juenc f):	. 0	1		
и	Examine		Sequentially list conditions,	Due to (or as a conseq	excoper	ua 2 adus A			
	35 M 8	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O M A	017.1	41			
	and al-trar	Examin	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	<del></del>			
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687	ificate g phy as the	0							
Вох	n cert andin use	M	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy II death 3.⊟Ectr	ppic pregnancy		23d. Date of deliver	•
	that the death certific ed by the attending p detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		er (specify)		Month	Day Year
P.0	at the by th	hys	9 □ Unknown				ag. Bitta		a source of death?
	Se Ded	ρ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the under	ying cause given in Part I.		bacco use contribute to the es 2 ØNo 3 ☐ Proba	ably 4 □Unknown
Vital Records,	w requir been si should I	Completed	<u> </u>				-		
ec	law has b	npie					24a. Was a autops perfor	sv prior to com	sy findings available apletion of cause of
H H		Co					1 ☐ Yes	2XNo 1 ☐ Yes	2 🗆 No
Vita	sicien: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only or		
of	ding Physicien: The I h. After this certificate ha funeral director, page	To.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	L DOA 4 LEANUISIII		ence 6 Other (Specify	)
no D	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work?			
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street,	factory, office		treet and Number or Rural	Route Number,
Ö	al or after	Certification:	4 Homicide determined	building, etc. (Special	ry)		City or Tow	n, Siale)	
	ospit. hours unere	cai (	29a. Certifier 1 Certifying Ph	ysician: To the best of my knoniner: On the basis of examina	owledge, death occ	curred at the time, date and pl	ace, and due to the c	ause(s) and manner as sta	ated. the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certificy completely illed in by the funeral director.	Medicai	one)	and manner stated.					
	To To	2	29b. Signature and title of certifier	NX		29c. License number	27	9d. Date signed (Month, L	
,	m		1 grat luck	171		100112	/	1//	0
_	3		30. Name and address of person who	10 821		claw St. F.	sulli mes	ED MD 213	201
	Sta Regist		31. Date filed (Month, Day, Year) SFP 1 1 2006	Registrar's Signature &	de la conte				

		•	1 → For State Registrar	State of Ma	aryland /	Depa Cer	artmen tificat	t of H e of L	ealth a D <i>eath</i>	ind M	ental Hygi	ene2 0	06	28660
	Physici	30	1. Decedent's Name (First, Middle, Last								2. Date of Death Month		ο Xear	3. Time of Death
	/Medic	-		ionette	Holt	:					Septembe	<del></del>	2006	6:00 a м
	Examin	er	4a. Facility Name (If not institution, give	_			-		Location o	f Death		4c. County		imore
			2331 Turkey Point  5. Social Security Number 6. Se		e (In yrs. last l	hirthday)		1 Year	If Under a	24 Hrs.	8. Date of Birth			lace (State or Foreign
	Funeral Director			M 217F	91	Yrs.	Months	Days	Hours	Min.	July 7,	Year) 1915	Mary	try)
			Usual Residence of Decedent								July 1		1	
	thow	_	10a. State 10b. County		10c. City, To	own or Lo	cation						1	Od. Inside City Limits
	Ba-f s	cto	Maryland Baltimore	9	Essex									1 ☐ Yes 2 ☐ No
	with ti		10e. Street and Number 2331 Turkey Point	Poad			10f. Zip	212	221		10	g. Cilizen of t	What Coun USA	itry?
	filed within 72 hours after death with the Maryland Hygiene. Other then "naturel", or items 23s or 28s-1 show ent, Its Madical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13 V	Was Decer			nin? (Spe	cify Yes or No-		e - Americ	an Indian
	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯	No	į				Puerto F	cify Yes or No- Rican, etc.)		ck, White,	
93	ei', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	1 🗆 Yes	2 <mark>⊠</mark> No	Specify:			Specif	v: Wh	ite
2-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		16	(Give	dent's Usua kind of wo	rk done d	turina most	of workir	ng 1	6b. Kind of B	usiness/Ind	dustry
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and	ad be contact to the	Be C		czewicz					TO. WOULD		ntonina	Zie	_	
Ξ	Should od Me mari imati	욘	19a. Informant's Name/Relationship (T)	rpe, Print)		9b. Mailin	ng Address	(Street a	and Numbe	r or Aura	Route Number,	City or Town,	State, Zip	Code)
ž	alth a		Kathleen Zahradka	a (daught	ter) 6	602 G	reyho	ound	Road	Ess	sex Mary	land 2	1221	
ore,	of He of He litem		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ I	Company from Chata		tery, cren	natory or o	ther place				0c. Location		
Ĕ	Pag ment ant: it ury o		Donation 5 Other (Specify)		Holly	7 Hil	.1 Mer	n Gar	rdens	9/11	/06	Baltim	ore C	o. Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in a file of 1884 is show important: if item 27 is marked other then "nature!', or items 28a or 28a-f show important property traumatic event, the Medical Examinar must be notified at one.		21. Sil nature of Fineral Service Licens	-					s of Facility Easte:	DI	zdzinsk zenue Es			
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rds, P	quires that in signed build be deta	ρ	Part II. Other significant conditions co	ntributing to death b	ul not resulting	g in the ur	nderlying c	ause give	en in Part I.			acco use coni		e cause of death?
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Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only one	)		
on of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funarel Director: After this certificate he completely filled in by the funeral director, page	tlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju	ry 28b	Outpation o. Time of Injury		8c. Injury Work	4 🗀 1401	2	ne 5X Resider 8d. Describe hov			()
Divisi	at or Attender after death Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	, farm, stre	eet, factory	, office		2	8f. Location (Str. City or Town,		ber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funarei I completely filled	edical C	29a. Certifier 1 ☑ Cartifying Phy (Check only one)	sician: To the best iner: On the basis o and manner st	f examination a	ige, death and/or inv	n occurred vestigation	at the tim	e, date and pinion, deat	d place, a	nd due to the car ad at the time, da	use(s) and ma te and place,	anner as st and due to	ated. the cause(s)
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	13-		30 Name and address of person who c	LYDEM	jn 15	911	Print)	111-1	DE	PII.	114 7,1	BALT	to a	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 1	2005 <sup>32. Registr</sup>	ar's Signature	As d	and the same	Buch						

State Registrar

		19	For Stata Registrar	State o	f Marylan	d / Depa	artment of H	lealth an Death	d Mental Hy	giene	2006	28662
1	Physici /Medic		1. Decedent's Name (First, Middle R & CHEST		HASK	(N-S			2. Date of D Month	eath Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution 2508 Salem Str 5. Social Security Number		mber) 7. Age (In yrs. i	ast birthdav)	4b. City, Town, or Balti If Under 1 Year	more			County of Death	olace (State or Foreign
4	Funeral Director		218-46-9874 Usuaf Residence of Decedent	1∭XM 2□F	58	Yrs.	Months Days		#rs. 8. Date of B (Month, D) 01/29/		Mary]	and
	r 28e-f ehov	Director	Maryland  10e. Street and Number			Baltim		<u> </u>		10g. Citiz	en of What Cour	1 Yes 2 No Nontry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-1 show eny injury or other traumatic event, the Medical Examinational Leading an once.	by Funerai	2508 Salem St.  11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Deci	2 💢 No /e	'	f Yes, specify Cuba	ispanic Origin'	? (Specify Yes or N uerto Rican, etc.)		A. 4. Race - Americ Black, White, Specify: Blac	etc.
Maryland 21215-0036	led within 72 ho tygiene. her then "natur nt, the Medical	Completed	(Specify only higher Elementary/Secondary (0-12) 12	t's Education st grade completed) College (*	1-4or 5+)	(Give life. L	dent's Usual Occupi kind of work done of DO NOT use retired	during most of		Cons	d of Business/In	ŕ
ryland	hould be fi id Mental H marked of matic ever	To Be	17. Father's Name (First, Middle, Earl Haskins  19a. fnformant's Name/Relations			19b Maifin	ng Address (Street	Irene	Name (First, Middle Moore r Rural Route Numl			Codel
	os 1 and 2 si of Health and Item 27 is r other traur		Eleanor Hubbar 20a. Method of Disposition	d-Haskins,	20b. Pt	3701 lace of Dispo		ive, Ba	altimore,	Mary:		215
Baltimore,	permit. Page Department of Important: If eny injury or once.		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	ipecity)	State	ro Cre	ematory In	nc. 09/	/11/2006 The Derricave., Bala	ck C.	Jones F	Maryland 7/H, P.A. and 21215
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to	RONA  (or as a consequ	RY (		1 7	USEASO			Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. DIABETES  Due to (or as a consequence of):										
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregnal wirth 2 Fetaf lant at time of de own	death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ery Day Year
ords, P.	w requires that the same of th	by	Part ff. Dther significant condition	2 F N	AL	FAL	LART		10	tobacco us		ne cause of death?
al Rec		Completed		PHERAC	VA	sca	CAL		perf	opsy ormed? 2 No	prior to cor death?	psy findings available inpletion of cause of 2000
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, to	ation: To Be	25. Was case referred to medica examiner?  1 Payes 2 No  27. Manner of Death  1 Payer 5 Pendir 2 Accident investi	Hospital: 1 1 1 28a. Date (Moning	<del></del>	ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 ☐ Nursin	Death (Check only g Home 5, Res 28d. Describe	idence 6		v)
Divis	oital or Atte urs after de prei Directo	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place buildi	ng, etc. (Specify	·)	eet, factory, office		City or To	wn, State)		l Rout <b>e</b> Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2   Medical one)		asis of examinat ner stated.	ion and/or inv	estigation, in my op	pinion, death o	ccurred at the time,	date and p	lace, and due to	the cause(s)
•	H		30. Name and address of person	who completed caus	e of death (Item	23a) (Type,	Print) 7AW 1(	BAC	TIMORE	407	18/0	0
4	Sta Registr	te	31. Date filed (Month, Day, Year) SEP 1 1 20	32. R	egistrar's Signat	Coest	U					

			1 - State Amend #26 P Registrar Amend #31		Cei	rtificate of	Death			
	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Day Year	
	/Medic		4a. Facility Name (If not institution, giv	Margaret	Helen	Helwig  4b. City, Town, o	r I continue of De	-	2, 2006 4c. County of De	2:35 A M
•	Examin	er	3.1				erry Hal			ann nore Co.
	Funeral		Ma Maison Assist 5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year	If Under 24 F	Irs. 8 Date of Birt	h O.B.	
	Director			□м адк 87	Yrs.	Months Days	Hours M	lin. (Month, Da	y, Year) (	inthplace (State or Foreign Country) aryland
	pu ,		Usual Residence of Decedent							
	ehov	ት		16	Oc. City, Town or Lo	cation	Ralti	more City		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N	Director	Maryland N/A			10f. Zip Code			10g. Citizen of What 0	
	with Be or	iOi		al Otros ot		101. 2ip Code	21224		United St	· _
	death ms 2;	Funerai	139 South Bould	12. Was Decedent Eve	r in U.S. 13.1	Was Decedent of H		(Specify Yes or No- lerto Rican, etc.)		
0	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				ierto Rican, etc.)		ite, etc.
3	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f ehow fa Medical Exacilinar mant be notified at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
ה	"natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	working	16b. Kind of Busines	s/Industry
7	withir ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		ousewife	<b>a</b> )		Own Hom	10
ט ס	filed Hygid Sther ent, I	ပို	12 Years  17. Father's Name (First, Middle, Last)	)	II.	JUSEWILE	18. Mother's N	vame (First, Middle,		ie
Maryland ZIZIS-0036	should be filed within 72 hours after death with the Marylan and Mental Hygiene. • marked other than "natural", or Items 23s or 28s-f show umatic event, the Medical Exacilizer must be notified at	To Be	Frederick Munch	n				Emma	Dorothy Zi	.ck
ary	and N ie mei		19a. Informant's Name/Relationship (	Type, Print)					r, City or Town, State,	
Ξ.	ges 1 and 2 should it of Health and Men if item 27 is marks or other treumatic		Joyce Rice (Da	aughter)	7200	6 Bridge	Wood Dr	rive Balt	imore, Mar	yland 21224
baitimore,	Pages 1 nent of He ant: If iter ary or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State 7	_	natory or other plac	· 1	Date	20c. Location - City o	r Town, State
	tment tant:		4 ☐ Donation ∫5 ☐ Other (Specifi	v) ,//	Gardens o			/5/2006		, Maryland
D D	permit. Page Department of Important: If any Injury or once.		21. Signstury of Juneral Solvice Lioe	The world	- 11				Dundalk, Maryland	Inc. 21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of dyin	ng, such as card	liac or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			card	4) 1005	cela Di	10	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):				•	/)
		ē	Sequentially list conditions,	b. Due to (or as a co	элзөциөлсө оП;					
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ĵ	certificate be executed ding physicien and use as the burlal-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
00/0	cate be	dical		d.						
ŏ	e as t	Med	IF FEMALE:							
ב ב	eath certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	Day Year
	by the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown	e or death 5L	Other (specify)				,
)	res that igned by be deta		Part II. Other significant conditions c	ontributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Ļ	n sign	ed by						1 🗆 Y	es 2 AND 3 P	robably 4 Unknown
Ļ		-								
Ľ	aw requir ss been si 2 should	를						24a. Was a	n 24b. Were a	utopsy findings available
ı necoldə, r.	The lar ate has page 2	Somple			-			- autops perfor	med? prior to death?	utopsy findings available completion of cause of
ı necolus, r.	The ate h page	Be Completed	25. Was case referred to medical examiner?					autop: perfor 1  Yes  Death Check only or	med? death?	s 2 No
אומו חפכטומא, ר.	Physicien: The this certificate hal director, page	To Be	examiner? 1 Tes 2 Se	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing	autope perfor 1 ☐ Yes Death Check only or Home <del>5 ☐ Re</del> sid	ence 6 \( \frac{1}{2}\) ther \( (Spain) \)	s 2 No
or vital necolus, r.	ding Physicien: The h. After this certificate h funeral director, page	To Be	examiner? 1 Yes 2 He  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injun Worl	er: 4  Nursing y at k?	autope perfor 1 ☐ Yes Death Check only or Home <del>5 ☐ Re</del> sid	med? death?	s 2 No
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or vital necolus, r.	Hospital or Attending Physicien: The Ahous after death. Funered Director: Atter this certificate hely filled in by the funeral director, page	Certification; To Be	examiner?  1 Yes 2 Is  27. Manner of Death  1 Natural 2 Accident investigation 3 Surcide determined  29a. Certifier  1 Certifying Ph	28a. Date of Injury (Month, Day Ye	28b. Time of Injury  At home, farm, stre  Specify)  y knowledge, death amination and/or inv	M 1 □	er: 4 Nursing y at k? Yes 2 No	autop: perfor 1 Yes  Death Check only or 28d. Describe h. 28d. Describe h. 28f. Location (S. City or Tow.)	med? death?  2 2 No 1 Ye  ne)  ence 6 2 Other (Spoow injury occurred  treet and Number or Fin. State)	Assisted  Assisted  acify/Living  ural Route Number,
or vital necolus, r.	Attending Physicien: The or death.  ector: After this certificate h by the funeral director, page	To Be	examiner?  1 Yes 2 Dele  27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (Systems: To the best of miner: On the basis of exa and manner stated.	28b. Time of Injury  At home, farm, stre  Specify)  y knowledge, death amination and/or inv	M 28c. Injuny Word 1 □ seet, factory, office  coccurred at the time restigation, in my of the company of the co	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	autop: perfor 1 Yes  Death Check only or 28d. Describe him 28d. Describe him 28f. Location (S City or Town cee, and due to the courred at the time, described in the courred at the time, described in the course of	med? death?  2 2 No 1 Ye  ne)  ence 6 2 Other (Spoow injury occurred  treet and Number or Fin. State)	Assisted  acity/Living  fural Route Number,  s stated. e to the cause(s)
or vital necolus, r.	Hospital or Attending Physicien: The Ahous after death. Funered Director: Atter this certificate hely filled in by the funeral director, page	edical Certification; To Be	examiner?  1 Yes 2 Island  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (Sysician: To the best of miner: On the basis of exand manner stated.	28b. Time of Injury  At home, farm, strepecify)  Ty knowledge, death amination and/or inventions.	M 28c. Injuny Word 1	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	autop: perfor 1 Yes  Peath Check only or 28d. Describe his 28d. Describe his 28d. Location (S City or Tow.)  Loce, and due to the courred at the time, described in the courred at the time, described in the courred at the time, described in the course of	ence 6 Other (Sp. ow injury occurred  treet and Number or Fin. State)  ause(s) and manner a late and place, and du	Assisted  Assisted  Assisted  acity/Living  fural Route Number,  s stated. e to the cause(s)
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or vital necolus, r.	Hospital or Attending Physicien: The Ahous after death. Funered Director: Atter this certificate hely filled in by the funeral director, page	Medical Certification; To Be	examiner?  1 Yes 2 Island  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (Sysician: To the best of miner: On the basis of exand manner stated.	28b. Time of Injury  At home, farm, strepecify)  Ty knowledge, death amination and/or inventions.	M 28c. Injuny Word 1	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	autop: perfor 1 Yes  Death Check only or 28d. Describe him 28d. Describe him 28f. Location (S City or Town cee, and due to the courred at the time, described in the courred at the time, described in the course of	ence 6 Other (Sp. ow injury occurred  treet and Number or Fin. State)  ause(s) and manner a late and place, and du	Assisted  Assisted  Assisted  acity/Living  fural Route Number,  s stated. e to the cause(s)

			For State	State of Maryland / Depart	ment of Health and Nicate of Death	Mental Hygier	711116 28664
	Physici	an	Registrar  1. Deceders's Name (First, Middle, Las	<del></del>	iodio oi bodiii	2. Date of Death Month	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number) 41	City Town, or Location of Death	September	4c. County of Death
	Funeral		5, Social Security Number 6. Se		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month Day, Yea	9. Birthplace (State or Foreign
	Director	2	Usual Residence of Decedent	76 Vrs.		10-26-5	of Moranicacine
	72 hours after death with the Maryland naturel', or Hems 23a or 28e-f show dical Examinat must be incillised at	tor	10a. State 10b. County	10c. City, Town or Locati	an CV		10d. Inside City Limits 1 ★Yes 2 → No
	with the	I Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
	ter death Items 2	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes No	Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	hours af turel', or al Exam	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Yes 2 No Specify:	106	Specify: Black
21215-	within 72 ene. then "nal	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seodochy (0-12)	le completed) (Give kind	's Usual Occupation d of work done during most of work NOT use retired)		Kind of Business/Industry
land 2	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show litem 27 is marked other then "neturel", or items 25e or 28e-f show other traumatic event, The Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maide	en Sumame)
Maryla	should bund Ment marked	To	Thineas Dal 19a. Informant's Name/Relationship (7)	TON  JOB, Pari Daug 1 19b. Mailing A	Address (Street and Number or Rus	ral Route Number, City	r or Town, State, Zip Code)
	1 and 2 Health a em 27 ls		Shortea J. Pa	20b. Place of Disposition		Aue 20c.	Location - City or Town, State
Baltimore,	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	DING 14e	Moriel fortal	9/06 B	altimore, MD
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	Var	ame and Address of Facility 1905 Was Live	e Fune	FOL SERVICES
			shock, or heart failure. List only of Immediate Cause (Final		1	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	lure Fail 1	re	5 years
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury	Due to (or as a consequence of):	atory rains	10	16 years
h	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			10 years
68760,	ificate be g physici as the bu	edical	•	d			
Box.	The law requires that the death certificate be executed tae been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of death 5 ☐ Ot	topic pregnancy her (s <i>pecify</i> )		23d. Date of delivery Month Day Year
P.0	that the de led by the a detached			9☐Unknown  ntributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	w requires that been signed I should be det	ted by				1 □ Yes	2 No 3 Probably 4 □Unknown
Rec	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	
Vital	ician: certific rector,	o Be C	25. Was case referred to medical examiner?	Hospital:	Othor	h (Check only one)	
of	ling After	<del>-</del>	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?  M 1 Yes 2 No	ome 5 Residence 28d. Describe how in	
Division	al or Atte after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attenc within 24 hours after death To the Funerel Director; completely filled in by the I	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exam	rsician: To the best of my knowledge, death oc inar: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To th Withir To th COMP	Me	29b. Signature and title of certifier  Sandra L.	Swann	29c. License number AT 24 38 QL	29d. D 500	Date signed (Month, Day, Year)  PHOMBEV 1, 2006
	1		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type Prin	nt)	11 - 1	tember 1,2006
	) Sta	ite	Sandra L. Su. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	MEMORIAL	HOSPITA	A, MIS
	Registi	ar	SEP 1 1 20	U6 Palesar St. 150	SEL.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20c Per the of Maryland / Department of Health and Mental Hygiene 2 For Amend #20c Per TTI G859 9/11/00 Jn. Registrar Amend #23e Per Phy G859 9/21966 if inate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** DAVID HIRSCHHORN 40 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Modfital of Baltinione Baltimore Ut If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth **Funeral** 1 M 2 □ F 0471671918 136-01-4637 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f ehon nutified at Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ?7 is marked other then "natural", or iteme 23a or traumatic event, the Mayloal Experiment must be 21208 725 MT. WILSON LANE UNIT 411 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Ass, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married
3 Widowed 4 Divorced 1 Yes 2 No Maryland 21215-0036 Specify: Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HIRSCHHORN AMELIA EPHRAIM ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE UNIT 411 - BALTIMORE, MD 21208 BARBARA B. HIRSCHHORN / WIFE f Health i Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5

Day

6

Year

2006

N/A

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 21 No

CZECHOSLOVAKIA

4c. County of Death

U.S.A.

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, et

WHITE

MANUFACTURING

KORNFELD

40

40

28665

3. Time of Death

02: IS A M

Reisterstown OHEB SHALOM MEMORIAL 109/08/2006 RANDALLSTOWN, MD 22. Name and Address of Facility

SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. down Immediate Cause (Final disease or condition resulting in death) SERSIS Due (or as a consequence of): Norcardia freumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Due to (or as a consequence of)

21. Signature of Funeral Service License

IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

3□ DOA

23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient

'au

24a Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 1 ☐ Yes 26. Place of Death (Check only one)

Other. 4 Nursing Home 5 Residence 6 Other (Specify)

2 No 3 Probably 4 nknown

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Matural

2 ☐ Accident

3 ☐ Suicide

4 | Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP

State Registrar

DHMH 17 Rev 1/2001

Nirschem

Publich as

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

signed by the a

rector, page 2 s

: After this certification,

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending

death,

within 24 hours after death To the Funeral Director: completely filled in by the

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

			For State Registrar		State of	Marylar	nd / Depa	artmeni <i>tificate</i>			and Me		giene Reg. No.	611	06	28	3666
			Decedent's Name (First, Midd	fle, Last)							2	. Date of Dea	ath			3. Time of	
	Physici /Medio		Bertha				H	ents	che		5	epten	ber		ear 2006	15:1	5 M
À	Examir		4a. Facility Name (If not institution	-		iber)			Town, or L		of Death	1	4c.	County of	Death		
			Johns Hopkins			7 4 //-	145-W 4- V	Ba1	timo	re If Under 2	24 Hrs. I a	- 18:					
	Funeral Director		5. Social Security Number 185–16–9904	6. Sex 1 □ N	4 2 XF	7. Age (In yrs. <b>}</b>	34 Yrs.	Months	Days	Hours	Min.	Date of Birt (Month, Da)	y, Year)		Countr		
	b		Usual Residence of Decedent								μι	me 20	, 19	22 <u>F</u>	enns	sy1var	11a
	arylan show		10a. State 10b. Count	/			ty, Town or Lo								100	d. Inside Ci	-
	8a-1	Director					Baltimo									1XX Yes	2   No
	with t	吉	10e. Street and Number	A	_			10f. Zip						zen of Wha	at Countr	y?	
	leath ne 23	Funeral	3809 Bayonne			dent Ever in U	.S. 13. V	212		nanic Orio	nin? (Specif		U.S.	A. 14. Race	American	n Indian	
ယ	or iter	F.	1 Never Married 2 Ma		Armed For	ces? 2⊠No			X		, Puerto Rio	y Yes or No- can, etc.)	1	Black,	White, et	tc.	
<u>ဇ</u>	ours a	d by	3	d	If Yes, Give Year or Da	tes:		I□Yes 2	2 <u>x</u> No	Specify:				Specify: C	auca	slan	
<u>7</u>	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-f ehow Te Madical Exercitier must be notillied at	Completed	15. Decede (Specify only high	nt's Educa est grade (	tion com <i>pleted)</i>		16a. Deced	lent's Usua kind of wor	l Occupat k done du	ion ring most	t of working		16b. Ki	nd of Busin	ness/Indu	stry	
12	within then then	m du	Elementary/Secondary (0-12) 12th grade		College (1-	4or 5+)	Homem		e retired)				0	Ueme			
о В	filed Hygir other		17. Father's Name (First, Middle	, Last)			nomem	akei	1	8. Mother	r's Name (F	First, Middle,		Home			
<u>a</u>	lid be fental rked c	To Be	Stanley Balca	itis						Isabe	elle V	Vinslo	w	,			
a <sub>1</sub>	should be man	_	19a. Informant's Name/Relation	ship (Type	, Print)		19b. Mailin	g Address	(Street an	id Numbe	r or Rural P	Route Numbe	r, City o	r Town, Sta	te, Zip C	Code)	
∑ ∑	and 2 saith n 27 i		Christine Boe	rner,	daugl		The second secon				ast Pa	lmett	o, F	lorid	a 3	34221	
Baltimore, Maryland 21215-0036	of He of He if item		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation	3 ∏Rer	noval from S		Place of Dispo cemetery, cren				Date			cation - Cit			
Ē	. Pag tment tant: jury o		4 Donation 5 Other (	Specify)		[Du]	Laney V	•		1	-	200		imoni	_		
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and International Figure 1 is marked other then "naturel", or fleme 28a or 28a-f show any injury or other traumatic event, Its Medical Exercities must be notified at 2004.		21. Signature of Furneral Service	Licensee			6	. Name and 415 B	d Address elai:	of Facility r Roa	<sup>y</sup> Mille ad. Ba	er-Dippolitimo	pel re. :	Funer Marvl	al H	lome, 2120	Inc.
			23a. Part1. Enter the disease, of shock, or heart failure. Lie	only one	tions that ca cause on ea	used the deat ich line.									P.	Approximate	e ween
į F	Physician		Immediate Cause (Final disease or condition	а	Bro	in He	erniat	in								Onset and [	Jeath
î.	/Medical Examiner		resulting in death)		Due to (d	or as a consec	juence of):			`						. 0	
	1	Je .	Sequentially list conditions,	h b		tracr or as a conseq		. He	Mor	rha	.ge					.000	
	uted I Insit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺		ando	11	i i			M.					1.4%	
o,	exection and and rial-tra	Еха	that initiated events resulting in death) Last	c.		or as conseq		7								757.57	r -
8760,	cate be executed physicien and the burial-transit	dical		d													
	actifica ing ph e as th	Med	IF FEMALE:		-								- 10		-		
Вох	requires that the death certifics leen signed by the ettending ph hould be detached for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	230	1☐Live bir	ome of pregna th 2 ☐ Feta	death 3	Ectopic pre					2	3d. Date o			rear
o O	res that the de signed by the e be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregna 9□Unkno	int at time of d wn	leath 5	Other (spe	ecify)					70101111		-, .	Out
م` ا	that t		Part II. Other significant condit	ions contri	buting to dea	ath but not res	ulting in the ur	derlying ca	use given	in Part I.		23e. Did to	bacco u	se contribu	te to the	cause of d	eath?
Division of Vital Records,	quires n sign ald be	d by										1 🗆 Y	es 2[	]No 3[	Probab	oly 4 🗆	Inknown
င္ပ	sw requir s been si s should	Siete										24a. Was a	an	24b. Wer	e autops	sy findings a	available
æ	The law ite hes b page 2 s	Completed										autop perfor 1 Yes	med?	prio dea	r to comp th?	oletion of ca ☐ No	ause of
<u>ra</u>		BeC	25. Was case referred to medical examiner?	al						26. Place	of Death (C	Check only o	2 (No		105 2		
<u>&gt;</u>	d is	2	1 ☐ Yes 2 📉 No	Hos	pital:	patient 2	ER/Outpatien	3 DO	A Other:	4 □ Nur	rsing Home	5 🗆 Resid	ence 6	Other (	Specify)		
ב	ing Ph	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ing	28a. Date of (Month	f Injury I, Day Year)	28b. Time of Injury		Bc. Injury a Work?			d. Describe h	ow injury	occurred			
Sic	Attending ir death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Could		On Plans	of lainer. At b	ama farm atu	M		s 2 N		Landing (C	*****	4 \$1			
<u>≥</u>	tet or Attend s after death bi Director: / ed in by the f	Certification:	4 Homicide determination	mined	buildin	g, etc. (Specif	ome, farm, stre	eet, ractory,	, опісе		281	Location (S City or Tow			or Hurai F	10ute Numi	ber,
	To the Hospitel or Attending, within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier Certifyi (Cirack only one) / 2 Medica	ng Physic Examine	ien: To the l	sis of examina	wledge, death	occurred a estigation,	at the time in my opir	, date and non, deat	d place, and h occurred	due to the oat the time, o	ause(s) date and	and manne place, and	er as stated	ed. ne cause(s	)
	To the within Comple	Me	29b. Signature and title of certific	ar				29c.	License r	number			29d. Date	a signed (A	Aonth, Da	y, Year)	
)			1	IAn	<u></u>	00		C	RES	-0	00		iont	omh	0 -	( )	006
4	6		30. Name and address of persor	who com	pleted cause	of death (Iter	n 23a) (Type, I	Print)	1		~ ~		,ey	CVICO	_1_	0 ~	
			31. Date filed (Month, Day, Year	00	600	Nov k	h Wol	te S	+ 1	Balt	rimor	e Mi	) 2	128	7		
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			1 - For State Registrar	State of N	/larylar	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of Healt of Dea	h and M <i>th</i>	lental Hy	giene Reg. No	200	16	2866
			Decedent's Name (First, Middle, I	.ast)						2. Date of De	ath			3. Time of Death
	Physici /Medi		ALVIN EDWARD JEI	NKINS, SR.						Month O9	O <sup>L</sup>	4		1739 PM
	Examir		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, T	wn, or Locati	on of Death		4c.	County of D	eath	
			UNION MEMORIAL					TIMORE						
	Funeral			Sex 7. A		last birthday) Yrs.	If Under 1 Months	Year If Uni Days Hou	der 24 Hrs.	8. Date of Bir (Month, Da 04/15	th y, Year)	9.	Birthplac Country	
	Director		216-34-3429 Usual Residence of Decedent		67	115.				04/15	/193	9		MD
	land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d	I. Inside City Limits
	Many fet	ğ	MD		12/1	LTIMORE								1X Yes 2 ☐ No
	r 28s	Director	10e. Street and Number		.uni	LIT TUCKE	10f. Zip C	ode			10g. Cit	izen of What	Country	/?
	h with		3522 ELLERSLIE	AVE.			21	218			119	SA		
	deat	Funeral	11. Marital Status	12. Was Deceden	t Ever in U		Vas Decede	nt of Hispanic	Origin? (Spe	cify Yes or No		14. Race - A		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "naturel; or items 23a or 28a-f ehow event, the Madical Examiner must be notified at	Ď	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 € If Yes, Give Year or Dates	₹No		res, specii I∐Yes 2[	Cuban, Mex		nican, etc.)		Black, W		
2	72 honatu	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	lent's Usual	Occupation done during n	nost of worki	na	16b. Ki	ind of Busine	ss/Indus	stry
7	Aithin ne.	dr.	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life. L	OO NOT use	retired)		.9				
7	Hygien Hygien other the	ខិ	12TH 17. Father's Name (First, Middle, Lat	-41		COI	NSTRUC					GENERA	L MC	TORS
Sur C	ntal H	Be		st)						(First, Middle,	, Maiden	Sumame)		
Ž	should be nd Mental marked ( umatic ev	ဥ	EDWARD JENKINS  19a. Informant's Name/Relationship	(Time Brief)		10h M-10-	- 4-1-1 (			PHIPPS				
<u>≅</u>	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic	i i	CATHERINE JENKII			1				Route Numb	_			
ē,	Heal Heal tem 2		20a. Method of Disposition	NO .		Place of Dispos	sition (Name	of		BALTIN ate	_		2121	SPRING RD
Baltimore,	Pages nent of int: if it		1 🔀 Burial 2 🗋 Cremation 3 4 🗎 Donation 5 🗎 Other (Spec		Θ	cemetery, cren BUTUS IN			00/11	/2006		JTUS, I		
≣	그 돈 뿐 글	li î	21. Signature of Funeral Service Lic	1	AR					/2006 LEY CHA				21227
Ď	Depa Impo any in		1/erlay	havit	/	1				VE., BA				21231
	-		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the deat	th. Do not ente	er the mode	of dying, such	as cardiac o	r respiratory a	rrest,	2014	A	pproximate iterval Between
	Physician		Immediate Cause (Final disease or condition	As J	.0	V 1								nset and Death
	/Medical		resulting in death)	Due to (or a		pirator	) Pr	57105	Jyru	drome				Iday
	Examiner		Sequentially list conditions	s Sen	451	Shock							1	day
	١٥١ (١٠٠٠)	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o a	s a consec	quence of):								- 1
	and trans	Examin	that initiated events resulting in death) Last	c. N	utro	peni	ci							> mouth
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09/89	ificate be executed physicien and and as the burial-transit	edicai		d	MIC	Lyw	iphou	(Tic_	Leuk	emia			- 1	1 1 years
_		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	алсу					1.	23d. Date of	daliana.	
O. Box	ne death the atter	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant a 9□ Uriknown	2 Feta	al death 3	Ectopic preg Other (spec					Month	Da	y Year
7.	that the de ned by the a detached t	Ph.	Part II. Other significant conditions	contributing to death	but not res	ulting in the un	deriving cau	se given in Pa	rt I.	23e. Did to	obacco u	se contribute	to the	ause of death?
ords	The law requires that the death cert to has been signed by the attending page 2 should be detached for use a	sted by								101	res 2	<b>Z</b> No 3□	Probabl	ly 4 □Unknown
vital Records,		Completed										24b. Were prior to death	o compl	findings available letion of cause of
<u> </u>	Attending Physician: In death.  cotor: After this certifical by the funeral director, p	Be	25. Was case referred to medical examiner?					7	ace of Death	(Check only o	ne)			
6	Physi this c	٤	1 Yes 2 No	Hospital:		ER/Outpatient				ne 5 🗆 Resid			oecify)	
	ding h. After funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	М 280	Injury at Work?		8d. Describe h	now injury	y occurred		
UNISION	Attendideath.	lical	2 Accident investigation 3 Suicide 6 Could not	be Diago of la	niuov - At h	ome farm stre		1 ☐ Yes 2		8f. Location (5	Stroot and	d Number or	Queal D	auto Alumba
<u> </u>	if or Attence after death i Director: d in by the	Certification:	4 Homicide determine	building, e	tc. (Specif	y)	ot, factory, c	ilica	_	City or Tox	vn, State)	)	nurain	oute reamber,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier 1 Certifying P (Checkenty one) 2 Medical Exa	hysician: To the best miner: On the basis and manners	ot examina	owledge, death ation and/or inv	occurred at estigation, in	he time, date my opinion, d	and place, a leath occurre	nd due to the d	cause(s) date and	and manner place, and d	as state	d. e cause(s)
	Fo the	Me	29b. Signature and title of certifier		.24.		29c. l	icense numbe	er		29d. Date	e signed (Mo	nth, Day	v, Year)
)	1		X 1/4 -	$A \prec$		- Ma	* 64	3774	0		,	29/21	1 1	\/-
	1		30. Name and address of person who	completed cause of	death (Item	MP n 23a) (Type, F	Print)	1134	0 6			110	110	14
	1		Quinting L.	Benson M	ND	Union	Mer	nonal	Hospi	tal -	Bat	timov	٠,	MP
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	Far's Signa	ature /	and ?	18	1				1	
			355 7 7		200 C BC	- J 13								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#5 perFH G859 9/15/06 WS
State of Maryland / Department of Health and Mental Hygiene 2006 28668 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Month Dav Year Physician 6:24 AM eptember 8 2006 lames /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner OF BALTIMORE Baltimore HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Nurge 5 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours 219-32-9 10 M 2□ F 70 Yrs. War Director vana Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heetth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside/City Limits other treumatic event, the Medical Examiner must be notified at Owings 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Mid Pines Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status orces' Black, White, etc. Tes 2 □ No Yes, Give 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Macy Elementary/Secondary (0-12) College (1-4or 5+) Salespersor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be lackson Brown 2 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Deportment of Heelth a Important: If Item 27 is any injury or other tree once. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - Pry or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Marxian 4 Donation 5 Other (Specify) 21. Signature of Funer Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** INFARCTION HOUR /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed NEUMDH Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, YEARS Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 1 ☐ Yes 2 1 No 1 Tyes After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) /, and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D25379 September 8, 2006 W. BELVEDERE 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) JOFFE M.D. SINAI STEVEN L. HOSPITAL OF BALTIMORE BALTIMORE MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1

1 2006

32. Registrar's Signature

	_	·	1 - For State Registrar		ryland / Dep Ce	ertificate of	lealth and N Death	Re	ene 200	
I	Physici /Medic		Decedent's Name (First, Middle, Las.	)	JEN	IMINGS		2. Date of Death Month September	Day Vee	3. Time of Death 12:55 AM
	Examin		4a. Facility Name (If not institution, give 1751 Drexel Road 5. Social Security Number 6. Se		(In yrs. last birthday	Du	Location of Death  ndalk  If Under 24 Hrs.	8. Date of Birth	4c. County of Dea Baltin	more Co.
	Funeral Director			M 2□F 84		Months Days	Hours Min.	(Month, Day, Feb. 9,		thplace (State or Foreign cuntry) irginia
	a-f show	ctor	10a. State 10b. County  Maryland Balt.	imore	10c. City, Town or I	ocation		Dundal:	k	10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28	al Directo	10e. Street and Number 1751 Drexel Road	3		10f. Zip Code	21222	10	g. Citizen of What Co United St	
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Medical Exaction man had be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. 13  D  WWII	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
1215-0036	ithin 72 hou ie. ian "natura i Medical E	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation	16a. Dec (Giv	edent's Usual Occup e kind of work done of DO NOT use retired	during most of work	sing	6b. Kind of Business	
Maryland 21	be filed within tal Hygiene.	Be	8 Years 17. Father's Name (First, Middle, Last)			Crane Op		e (First, Middle, M	aiden Sumame)	Industry
	s 1 and 2 should be the strain and Menta item 27 is marked other traumatic events.	70	Henry Jennings  19a. Informant's Name/Relationship (7)  Carol Jennings (1)	,, ,		ling Address (Street			City or Town, State, .	Zip Code) 1222
Baltimore,			20a. Method of Disposition  1★ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify,	Removal from State		position (Name of ematory or other place on Forest	(8)		Oc. Location - City or	Town, State
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens	100	D	the same of the sa	ss of Facility Funeral H		undalk, I	nc. 21222
	Pnysician /Medical		23a Part1. Enter the absease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a DEMENT	the death. Do not ele.  A consequence of):	nter the mode of dyin	g, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	K DISE	ASE			2 YEARS
68760,	ificate be executed g physician and as the burial-transit	edicai Exar	that initiated events resulting in death) Last	c. HYPOTO Due to (or as a	consequence of):					10 (0,40)
O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date of de Month	livery Day Year
rds, P	signed be de	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did toba		o the cause of death?
Vital Records,	The ate h page	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
	Hospital or Attending Physician: The 4 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time	of 28c. Injury	er: 4 ☐ Nursing Ho	th (Check only one ome 5 Pesiden 28d. Des ribe how	ce 6	icity)
Division of	ai or Attendi s after death. ii Director: A id in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuribuilding, etc.	ry - At home, farm, s (Specify)			28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely fin	edicai	(Check only 2 Medical Exam	vsician: To the best of iner: On the basis of and manner stat	examination and/or i	nvestigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Lugal	· MD	29c. Licenso	2032		1. Date signed (Mont	
10	14		JEHNIFER HAYASH	ompleted cause of de	ath (Item 23a) (Type				(Dalaa	
	Sta Registr		SEP 1 1 2006	Registra	rs Symature	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28670 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Month Year Jones Athaleen 2006 7:00 A M 6, Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Nursing Home Rossville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 M XXF Hours North Carolina Yrs. Director 18,1924 82 246**-**26**-**4625 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 items 23a 2703 Page Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Market Cahier 10 Years 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event ORR®. 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Rhodes Herman Bishop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 2703 Page Drive Mr. Richard G. Jones (Husband) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

■ Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 9/9/2006 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. oner art1. Enter the disease, o complications that caused t shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End demen **Physician** /Medical Due to (or as a consequence of) Examiner multintarc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burial-transit completely filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2☐ No Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation → □ Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

2006

21215-0036

Baltimore, Maryland

P.O. Box 68760.

Records,

Division of Vital

kwood Rd St

of death (Item 23a) (Type, Print)

09-06-06

			1 - For State Registrar		Marylan		artment of H			Re	3. No. 20	
İ	Physici /Medio	cal	Decedent's Name (First, Middle Regina     Regina     Aa. Facility Name (If not institution)	K	eyser		4b. City, Town, or	r Location o		Date of Death Month August		
	Examir	ier	Prince George 5. Social Security Number	's Hospita		last birthday)	Chever			Date of Birth	Princ	ce George's
	Funeral Director		218-18-7698 Usual Residence of Decedent	1□M 2□F	87	Yrs.	Months Days	Hours	Min. Oc	Date of Birth (Month, Day, 1 t 30,	(ear) 1918 (	9. Birthplace (State or Foreign Country) /irginia
	n the Maryland r 28a-f show	Irector	NJ 10e. Street and Number			y, Town or Lo Englew				10	g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ☐ No nat Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Sin proportent: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other treumatic event. Its Medical Examinar must be notified at once.	by Funeral Director	166 Velmont S  11. Marital Status  1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Deced Armed Force ned 1 Tyes 2	es? EXNo		0763 Was Decedent of H f Yes, specify Cuba		gin? (Specify i, Puerto Rica	Yes or No- an, etc.)		American Indian, White, etc. Black
Maryland 21215-0036	d within 72 hou giene. or than "natura . It e Medical E	Completed		ot's Education st grade completed)  College (1-4	4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired ctical Nu	during most d)	t of working		Sb. Kind of Bus	iness/Industry
/land	und be file Mental Hy arked other atic event	To Be	17. Father's Name (First, Middle, (Unknown)	Last)					rs Name (Fi 1 Tolso		aiden Sumame,	)
, Mar	and 2 sho saith and I n 27 is mu er treum		19a. Informant's Name/Relations Regina Bailey		)		ng Address <i>(Street a</i> Velmont S				-	tate, Zip Code)
Baltimore,	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate c	emetery, crer	sition (Name of matory or other plac t. Church		Date 9/6/0			ity or Town, State
Balt	Departi Departi Importu any Inji		21. Signature of Funeral Service	Lionsee	200	B	Name and Address arry O. W 784 Mary	laddy	Funera	al Home Lancas	ter. VA	
	death certificate be executed  By Aman Aman Aman Aman Aman Aman Aman Aman	dical Examiner	23a. Part. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aS Due to (or  bR  C.	used the death or line.  epsis r as a conseq espira r as a conseq ncepha. r as a conseq	uence of): tory F uence of): lopath	ailure	g, such as o	cardiac or re	spiratory arres	it,	Approximate Interval Between Onset and Death
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				23d. Date Mont	
ds, P.	es the gned be de	ρ	Part II. Other significent condition	ons contributing to dea	ith but not res	ulting in the u	nderlying cause give	en in Part I.				ute to the cause of death?
Y	The ate h page	Completed							_	24a. Was an autopsy performe	pri de	ere autopsy findings available or to completion of cause of ath? ] Yes 2 ( ) No
or Vital	yaic s ce direc	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatier		er: 4 ⊟ Nur	rsing Home		ce 6 □Other	
Division of	To the Hospitel or Attending Physician: within 24 hours stater death at 10 the Funerel Director: After this certifical completely filled in by the funeral director,	Certification;	27. Manner of Death  1 Pattural 5 Pendir 2 Accident investi 3 Suicide 6 Could determ	gation not be and Blace		28b. Time or Injury	Worl	yat k? Yes 2 □ N	No		r injury occurred	or Rural Route Number,
2	spitel or a lours after nerel Dire		4   Homicide	building	g, etc. (Specif	y) 		ne, date and	d place, and	City or Town,		ner as stated.
	thin 24 h	Medical	(Check only 2 Medical one)  29b. Signature and title of certifie	Examiner: On the bas and manne	sis of examina er stated.	tion and/or in	vestigation, in my of		th occurred a			d due to the cause(s) (Month, Day, Year)
)	5 with 5 no		· ghelo	1			72	75	7)		8/31	106
	4		30. Name and address of person	MBERDA	tch	3001	Print) HUSPIH	ALL	DR C	HUR	ely 1	no20785
	Sta Registi		31. Date filed (Month, Day, Year)	1 2006	gistrar's Signa	ture	recti.				/	

DHMH 17 Rev 1/2001

	1	For State Registrar	State of Maryland		nt of Health and N te of Death		iene <sub>ag. No.</sub> 2006	28672
Physicia /Medica	1	1. Decedent's Name (First, Middle, Last)	KNOK			2. Date of Deat	7- 06	3. Time of Seath
Examine		Peocility Name (If not institution, give str DENESUS HEAL	In CAKE	10/2	Town, or Location of Death	I	4c. County of Death	
Funeral Director	(	XJUXU-UUJ I	7. Age (In yrs. I	Yrs. If Und	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth Month, Day,	Year 9. Birth	plece (State or Foreign try)
Aaryland I show		Usual Residence of Decedent  10a. State; 10b. County:	10c. City	Town or Location	<u> </u>			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23e or 28e-f show r must be notified at	Direct	10e. Street and Number	Vt.		Cip Code	1	Og. Citizen of What Cou	intry?
irs after death wirs after death will, or items 23e	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 _Yes, 2 _Mo If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ican Indian,
ire, INIGITYIGITION 21219-0030 It and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondery (0-12)		16a. Decedent's Us (Give kind of viife polynot	ual Occupation vork done during most of work usb retired)	king	16b. Kind of Business/18 BA/ED: FU	BIEM
should be filed and Mental Hyg is marked other and its analysis marked other analic event,	lo Be	17, Father's Name (First, Middle, Last)	nl		ELIA	e (First, Middle, M	X	1
Te, Mary tand 2 shou Health and N tem 27 is ma		19a, Informant's Name/Relationship (Typ	S()U)	19b. Mailing Addre	ss (Street and Number of Rui VIIC AVE	194/tDi	MV1. 00/0	218
Pages 1 ar nent of Hea int: If Item irry or otha	1	20a. Metho of Isposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	/1 c	lace of Disposition (A emetery, crematory of	New 19-15	Date	POULUS	own, State
Dartimor permit. Pages Department of t important: If lite any injury or of once.		21. Signature of Funeral Service License	Scenic	1300	and Address of Facility	SEPH !	BALLS M	0,21200
Physician		23a. Part. 3 ter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.					Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of the consequence)	uence of): 130515	and 50	TROK	E	7 ( 0001 )
be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
ate be nysicie	cal	d.	Due to (or as a consequ	<b>30</b> 100 017.				
the death certificate by the attending phys	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1  Yes 2  O	ic. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 □Ectopic			23d. Date of deli Month	very Day Year
S,	ģ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the underlyin	g cause given in Part I.		bacco use contribute to	
0 8 8 C	ompleted					24a. Was a autops perforr	n 24b. Were au	topsy findings available completion of cause of
- C Q	Be Cor	25. Was case referred to medical examiner?					2 No 1 ☐ Yes	2 No
ng Phys ng Phys neral dii	၉	1  Yes 2  Yo	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 4 Nursing H  28c. Injury at Work?  1  Yes 2 No		ence 6 Other (Spec ow injury occurred	afy)
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac		28f. Location (SI City or Town	treet and Number or Ru n, State)	ral Route Number,
the Hospital hin 24 hours a the Funeral I npletely filled	Medical C				ed at the time, date and place on, in my opinion, death occu			
To the vithin 2 To the comple	Me	29b. Signature and two of entitier	7/12	1	29c. License number 0 -800 / 2 \$2 6		9d. Date signed (Month	
3		30 Name and address of person who con	mpteted cause of death (Item	n 23a) (Type, Print)	0-00/28 0		Honlyh	(2-0
Star Registra		31. Date filed (Month Pay War) 201	32 Registrar's Signa		U ENE	-51-5	JI EUITH	CGTE

State of Maryland / Department of Health and Mental Hygiene For State Registra 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month RAYMOND KLUVER 8:37 PM 6 09 06 05 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2 □ F 217-40-0815 63 Director Yrs. April 25,1943 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2000 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2106 Jasmine Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Truck Driver Trucking Industry 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked ony injury or other traumatic eveny injury or other traumatic eveny. te marked Peter Kluver Blanche Ward 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathryn L. Kluver (Wife) 2106 Jasmine Road Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) Hilltop Service Corp. 9/8/2006 Towson, Maryland 21. Signa ve of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OBSTRUCTIVE PULMONARY CHRONIC DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physicien Physician/Medicai the use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death signed by the at d be detached fo 5 Other (specify) o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed2 certificate 1 ☐ Yes 2 ☐ No 1□ Yes Division of Vital 2.23 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or A within 24 hours after To the Funeral Direct 4 | Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Hosica Collina MD RES-001 915/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESSICA COLBURN, MD JHBMC 4940 EASTERN AVE. BALTIMORE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2006 BROAR -Registrar

DHMH 17 Rev 1/2001

			For Amend Item	2State of M	Hrylaces of	9971119 Certifica	te of D	ealth ar Death	nd Me	ental Hygi	ene 20	006	28674
	Division		1. Decedent's Name (First, Middle, Last)						2	2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medio		John Luk	as						September		2006	7:25 AM
100	Examin	er	4a. Facility Name (If not institution, give			4b. City	, Town, or I	Location of	Death		4c. County		, (
			5. Social Security Number 6. Sec	ngton me	ge (In yrs. last birt		er 1 Year	If Under 24		8. Date of Birth	Anne		
	Funeral Director			ŽM 2□ F		Yrs. Months		Hours	Min.	(Month, Day, SEP 11.	<sup>Уваг)</sup> 1914		lace (State or Foreign try)
			Usual Residence of Decedent		91					SEF II,	1914		yland
	how		10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits
	Sa-f s	cto	Maryland Carrol	11			aneyt	own					1 □ Yes 2 □ No X
	ith the	Director	10e. Street and Number			10f. Z	ip Code			10	og. Citizen of V	What Coun	try?
	8 23e	ral	111 Ponytail La	ane 12. Was Deceden	t Ever in 11 C	13 Was Dag		.787	n? (Spec	ify Yes or No-		USA e - Americ	an Indian
	Item	Funeral	11. Marital Status  1 X Never Married 2 Married	Armed Forces	?	If Yes, sp	ecify Cuban	, Mexican,	Puerto R	ican, etc.)		ck, White,	
336	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 🗆 Yes	2 <b>∑</b> No	Specify:			Specify	. Wh	ite
ğ	be filed within 72 hours after death with the Maryland nat Hygiene.  ed other than "natural", or Items 23e or 28e-f show event, the Madisal Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a.	Decedent's Us (Give kind of w	ual Occupa	tion	nf workin	a 1	16b. Kind of B	usiness/ind	dustry
21215-0036	thin the way	nple	Elementary/Secondary (0-12)	College (1-4o	5+)	life. DO NOT	use retired)				M	usic	
	e filed within al Hygiene. I other than " vent, the Me		17. Father's Name (First, Middle, Last)		Mu	sic Tea				(First, Middle, N			
Maryland	a la b	Be										10)	
Ž	2 should be and Mental is marked eumatic ev	2	Ambrose A. Lukas  19a. Informant's Name/Relationship (7)		19b.	. Mailing Addre	ss (Street a			es A. C		State, Zip	Code)
<b>∑</b>	s 1 and 2 should f Heelth and Mer Item 27 is marke other treumatic		Beulah Bollon/Nie			11 Pony				eytown,			,
ē,	s 1 and 2 f Heelth Item 27 I		20a. Method of Disposition		20b. Place of	Disposition (N	ame of	1	Da		20c. Location		wn, State
9	Page: ient o nt: If ry or		t ☐ Burial 2 🖾 Cremation 3 ☐ F		<b>6</b>	Cremat			9/2/	/06	Balti	more.	MD
Baltimore,	permit. Pages 1 and 2 Department of Heelith s Important: If Item 27 ti any Injury or other tre 90028.		21. Signature of Funeral Service Licens	00		22. Name	and Address	s of Facility	Cren	nation S			
0	80 = 8		Edward A, Greg	orchik		299	Frede	erick	Road	l Balti	imore,	MD 21	.228
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	lications that caus ne cause on each	ed the death. Do not line.	not enter the mi	Pneur	, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	a. Acuto	Renc	1 Fa		-					Onsot and Dout.
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):							
		<u>-</u>	Sequentially list conditions,	b. Due to (or a	s a nonsequence i	of):							
	uted d ansit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_									
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or a	s a consequence	of):							
8760,	Tro law re, ulres that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use es the burial transit	dlcal		d									W W
9	ing ph	Med	IF FEMALE:									2 2 2 2	-
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death							te of delive onth	ery Day Year
	thet the death certific ed by the attending p deteched for use es	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9∐Unknown	at time of death	5 ☐ Other (	specпу)						
P.0	thet ti	유	Part II. Other significant conditions co	ntributing to death	but not resulting in	n the underlying	cause give	n in Part I.		23e. Did tob	acco use conf	tribute to th	ne cause of death?
Records,	ulres thei signed t	Ď	Failure to the	100					_	1 □ Ye	s 2 No	3 Prot	ably 4 Minknown
9	w requir s been si should	lete								24a. Was a	n 24b.	Were auto	psy findings available
	hysicien: The law his certificate has b I director, page 2 s	Completed by								autops perform	ned?	prior to co death? 1 ∐ Yes	mpletion of cause of
Vital	rtifica stor. p	a	25. Was case referred to medical					26. Place	of Death	Check only on			7
	Physicien: this certificated ral director.	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🕍 npa	tient 2 ER/Ou	itpatient 3 🗆 I	OOA Othe	ar. 4 □ Nur	sing Hom	ne 5 Reside	nce 6 Oth	ner (Specif	y)
0	ding P	<u>e</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. 1 Day Year) I	Time of njury	28c. Injury Work			8d. Describe ho	w injury occur	red	
Sio	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	One Plans of I	nium. At home for	M		/es 2□N		9f Location /St	reet and Numi	her or Purs	Il Route Number,
Division of	or A after of Direction by	Certification:	4 ☐ Homicide determined		njury - At home, fa etc. <i>(Specify)</i>	am, street, ract	ory, office		-	City or Town		JOI OI MUIE	a riodio reamber,
_	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Phy	rsician: To the be	st of my knowledge	e, death occurre	d at the tim	e, date and	i place, a	nd due to the ca	ause(s) and m	anner as s	tated.
	To the Hospital or Attending Phinith 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exam	iner: On the basis and manner	of examination an	d/or investigati	on, in my op	oinion, death	n accurre	d at the time, da	ate and place,	and due to	the cause(s)
/	1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Z	29b. Signature and title of certifier			2	9c. License	number			9d. Date signe		*
	(X)		· MM				158	458		C	41100	9	
1	) /		30. Name and address of person who o	ompleted cause o	death (Item 23a)	(Type, Print)	-0	0.	- /	Clen B	1	4 = 1	1.50/
			Juteel Schik	Scellen	208 CY	am M	the in	, Su	0	ten B	yme	MD	21061
	St. Regist	ate rar	31. Date flied (Month, Day, Year)	2006	strar's Signature	!							
		-1	7	130									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar	Ce	artment of Heritificate of L	eaith and iv Death	rental Hyg	eg. No. 20	06	28675
	Physicia		1. Decedent's Name (First, Middle, Las STEV	,		MAGW	000	2. Date of Dea Month Auらいろ	Day	Year 2006	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County		
			BON SECOURS HOSP	ITAL		BALTIM					
	Funeral Director		UNKNEENN	7. Age (In yrs.  XM 2□ F  43	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 03/16/	(63)	9. Birthpla Country	ice (State or Foreign y) MD
	death with the Maryland ma 23a or 28a-f ahow rrivat be notified at		Usual Residence of Decedent  10a. State  10b. County	10c. C	ity, Town or Lo	ocation				100	d. Inside City Limits
	a-fa	tor	MD	BA	LTIMORE	Ξ					1⊠Yes 2□No
	or 28	lre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Countr	y?
	23a	a	1001 BETHUNE RD.			21225			USA		
920	172 hours after death with the Marylar Patural', or itema 23a or 28a-1 ahow Idical Examinar must be motified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🖫 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American k, White, et BLACE	tc.
5	72 ho	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa kind of work done d	ition	ing	16b. Kind of Bu	siness/Indu	istry
Ÿ	thin 7	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retired)	) most of work	ing			
7	d with	Š	12TH		D]	ISTRIBUTOR	}		ADVER	RTISEM	ENT
	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumam	e)	
<u>a</u>	Ment Ment arkec	2	MARSHALL MAGWOOD				VIRGIN	IA GROSS	3		
<u>a</u>	2 sho and is mu		19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ing Address (Street a	and Number or Run	al Route Number	r, City or Town,	State, Zip C	code)
≥,	and palth n 27		TYRONE SMITH/BRO			04-B CHERR					
9	ges 1 at of He if item or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date	20f 9053 ion H	SELTR	5 FERRY RD
Ĕ	Pag ment ant: i		4 □Donation 5 □ Other (Specif)	) N	T. ZIO	N CEMETER	Y 09/0	08/06	LANDSD	OWNE,	MD 21227
Dail	permit. Departr Importu any njo		21. Signature of Funeral Service Licen	Mart.	2	2. Name and Addres	s of Facility WES EASTERN	LEY CHAV	IS, JR.	FNRL	. HM. 21231
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the dea	ith. Do not en					1	Approximate
	Dhusisian		Immediate Cause (Final		*			•			Interval Between Onset and Death
?	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		10N P	NNEMO	NIA			1/2 HR
	Examiner					E ASOI	TIS				A SHIP SHIP N
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse			, , , ,				
	Post is a	듵	Cause (Disease or injury	21	HEON	10 21 V	ER 1	DISEA	SE		NUMBURION
	be executed cian and burial-transit	Examiner	resulting in death) Last	Due to (or as a conse	quence of):		,				
08/P0	ficate be executed physician and the first than the purial-transit	edical		d HUMAN	IMM2	UNODEF	FILIENC	Y VI	RUS	21	NKNUNN
Q		ed							1		
C. BOX	of the death cert by the attending tached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dati Mor	e of delivery	y Day Year
7	requires thet een signed b nould be deta	by PI	Part II. Other significant conditions of	ontributing to death but not re	sulting in the a	underlying cause give	on in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
cords,	w requires the been signed should be det	D D	END STAG	E RENAL	D252=	A32		1 🗆 Y	es 2□No	3 Probat	bly 4 Unknown
ខ្ល	- O 75	Completed	HYPERTEN					24a, Was a	ın 24h V	Vere autoos	sy lindings available
ě	The law sete has b	E C			· ~ ~ ^			autop:	med?	death?	sy lindings available pletion of cause of
VITAI		မ င်	A)ZTER103C 25. Was case referred to medical	ZERSTIC I	1246	1 2136		1 Yes		☐ Yes 2	:□ No
	sician: certific irector,	o Be	examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2	TER/Outpatio	Othe	26. Place of Deat ac: 4 ☐ Nursing Ho			(0 ( )	
ō	Phys r this ral di	<b>I</b> -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe h			
Ö	ding I h. After funer	育	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Work	(? Yes 2 □ No		, ,		
DIVISION	Attending Physician: r death. ector: After this certific by the funeral director,	flca	3 Suicide 6 Could not b		home, farm, st			28f. Location (S	treet and Numb	er or Rural	Route Number.
S	P S in S	Certification;	4  Homicide	building, etc. (Spec	eify)			City or Tow	n, State)		
	To the Hospital within 24 hours of To the Funeral completely filled	Medical (	29a. Certifier 1 Le Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examinand manner stated.	nowladga das nation and/or in	th secured at the ternion nvestigation, in my op	is date and class pinion, death occur	and due to the c red at the time, o	ause(s) and ma late and place, a	nner as star and due to t	ted the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	N D		29c. License			29d. Date signed		
}			,	Mohis MO.		D2	3300		Ancon	ST 3	1 06
	3		30. Name and address of person who ろしかんた。カ	. PATE2.	200	OW 13A2	5E20V TV. 3T.	13427	10.172	>, 2	1223
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 1 2	32. Registrar's Sign	nature	posts					
			19F Bru I	4							

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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physician/ al Examiner  1. Decedent's Name (First, Middle,Last)  Tyra McClary  4a. Facility Name (if not institution, give street and number) Lot rear of 5100 block Beaufort Avenue  4b. City, Town, or Location of Death Baltimore  4c. County of Death 4d. County of Death Baltimore  5. Social Security Number 2. Date of Death August 30, 2006  4c. County of Death Baltimore  4c. County of Death Baltimore  5. Social Security Number 214-88-096  1			1- For State Registrar	State of Mary		ficate of L				. No. 200	16 286
Secretary Name of International Operations of Design (1997) and the Secretary Operatio			1. Decedent's Nar						2. Date of Death Month	Day Year	3. Time of Death 1127 hrs
2 14 - 28 - 29 6	Jai Exaiii	1116	-		umber)	4b	. City, Town, or Lo	cation of Death	August 30,		
214 - 88 - 096			Lot rear of	5100 block Beaufort Aver	nue		Baltimore				
The state of the Course with t			214-8	8-0969 <sub>1 M 2</sub> X <sub>F</sub>	0 , ,				-	Earnie	in Lintry)
The control of the	any				10c. City, To	wn or Location	n				10d. Inside City Limits
The control of the	show		MD	Baltimore	Winds	sor Mi	.11				1 Yes 2 XNo
Section   Sect	28a-f d at o	ect	10e. Street and N	umber			,		100	g. Citizen of What Cou	ntry?
Section   Sect	th the 23a or notifie	Ö				1.0					land to the Die et
Secrity Fift File Care   Secrity File File File File File File File File	ath wi items ist be	nera	11. Marital Status  1 Never Mari	ried 2 Married Armed f	Forces?						ican Indian, black,
1			3 10/1/dowed	1 Yes 4 Divorced If Yes, Give Yo	2 2 No	1 Y	res 2 X No	specify:		Specify: Afr	ican- rican
1	natura xamin				ade completed) 16					16b. Kind of Business/	Industry
1	n /2 nan "r	olete	Elementary/Sec			Ü	9			1st Commo	on Wealth
1   Memory   2   Cremation   3   Removal from State   KTng   Mem   Park   9/7/06   Woodlawn, MD   20   Department   2   Cremation   3   Removal from State   4   2   2   Name and Address of Fabrity   Wy   EF   F   P.A. of Balto   September   2   2   Name and Address of Fabrity   Wy   EF   F   P.A. of Balto   Name and Address of Fabrity   Wy   EF   P.A. of Balto   Wy   EF   P.A. of Balto   Wy   EF   P.A. of Balto   Wy	giene. ther the	Į į	17. Father's Name			rereco			(First, Middle, Ma	aiden Surname)	
1	ntal Hy rked o		Rooseve	lt McClary Sr	•						
1	nd Me is ma atic ev	ļ٤									
1   Memory   2   Cremation   3   Removal from State   KTng   Mem   Park   9/7/06   Woodlawn, MD   20   Department   2   Cremation   3   Removal from State   4   2   2   Name and Address of Fabrity   Wy   EF   F   P.A. of Balto   September   2   2   Name and Address of Fabrity   Wy   EF   F   P.A. of Balto   Name and Address of Fabrity   Wy   EF   P.A. of Balto   Wy   EF   P.A. of Balto   Wy   EF   P.A. of Balto   Wy	ealth a					LZIO	E. Madl on (Name of ceme	son St	Date Date	Balto. MI 20c. Location - City or	Town, State
Part   Enter this disease of read and seaso or condition resulting in death   Part   Enter this disease of the cause of death   Part	Pages 1.7		1 Burial 2	Cremation 3 Removal	from State K I'r	ng Mem	Park	9/7	7/06	Woodlawn	, MD
Security   Part   Color   Co	Depart Depart Impor injury		11/1	1/1/1/20		920	0 Liber	ty Rd.	, Rand	allstown	, MD 2113
Immediate Cause (Final diffese of condition resulting in death)  Beautiful Deputing Cause (Final diffese of conditions)  If any, leading to immediate Cause (Final diffese of conditions)  If any, leading to immediate Cause (Final diffese of conditions)  If any, leading to immediate Cause (Final diffese of conditions)  Due to (or as a consequence of):  Due to (or as a consequence				only one cause of each line.							Between Onset and
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past 12 months?    Pregnant at time of death   5   Other (Specify)	ate be hysicia e buria	Mad	IF FEMALE:		item#23a,2		perME.g859	<u>.9/28/06</u> '	<u>IT</u>	23d. Date of deliver	<u> </u>
29b. Signature and title of certifier  29c. Dicense number  O.C.M.E.  August 31, 2006  29d. Date signed (Month, Day, Year)  August 31, 2006  Pamela Southall, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	ertific iding p	ian/		hs?				Ectopic pregna	ncy	Month	Day Year
29b. Signature and title of certifier  29c. Dicense number  O.C.M.E.  August 31, 2006  30. Name Intractives of person who completed cause of death (Item 23a)  Pamela Southall, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	death of e atten f for us	Veic	1 Yes 2	No 9 M Hoknown		5 Othe	er (Specify)				
29b. Signature and title of certifier  29c. Dicense number  O.C.M.E.  August 31, 2006  30. Name Intractives of person who completed cause of death (Item 23a)  Pamela Southall, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	at the d by th etached	1 2		nificant conditions contributing	to death but not resu	ulting in the un	derlying cause giv	en in Part I.			
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20. Name Industries of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		N S	29b. Signature ar	and manner	rstated						
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	Y	1			11	24 6	enn Street, Ba	itimore, MD	21201		

			State of Maryland / Depa		_	•	
			_ FOI	tificate of Death		No. 2008	28677
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)  Cecil Edward Martin		2. Date of Death Month	Day Year	3. Time of Death 5:15 A M
	/Medic Examin		Cecil Edward Martin  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Septembe	4c. County of Deat	
		Ŭ.	Ivy Hall Geriatric Center	Middle River		Baltimor	
	Funeral Director		5. Social Security Number  234–18–3922  6. Sex 1 ☑ M 2 ☐ F  7. Age (In yrs. last birthday)  1 ☑ M 2 ☐ F  95  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y 02/16/19	ear) 9. Birti Co Wes	nplace (State or Foreign untry) t Virginia
	rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	eation			10d. Inside City Limits
	e Mary te-f eh	ctor	Maryland Baltimore Essex				1 ☐ Yes 2 X No
	with the or 26	Director	10e. Street and Number	10f. Zip Code 21 221	-	. Citizen of What Co U.S.A.	untry?
	deeth me 23 Coust	Funerai	342 Upperlanding Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto		14. Race - Ame	
980	ges 1 end 2 should be filed within 72 hours after deeth with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28e-1 show or other traumatic event, the Medical Examinar coust be notified at	þ	1 □ Never Married 2KDMarried 1 □ Yes 2 KDMo	Yes 25% Specify:	Hican, etc.)	Black, White Specify: Wh	
Maryland 21215-0036	within 72 ho ene. then "natur	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16	b. Kind of Business/	Industry
121	filed wi Hygien other th		17. Father's Name (First, Middle, Last)	18. Mother's Name		hoe Repai	r
land	id be f ental h ked of	To Be	John Franklin Martin	Emma Pair		our comand)	
lary	2 should be and Mental Is marked raumatic ev		19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or Rura	l Route Number, C		
	1 end 1 Health Iem 27 other tr			pperlanding Road,		e, Maryla c.Location-City or	
TOL	Pages nent of h int: If it		20a. Method of Disposition  1X□Surial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposicementary, crem  Cardens (			ltimore,	
Baltimore,	permit. Pages Department of Importent: If t eny Injury or o			Name and Address of Facility Bruzdzinsk			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	140/ Old Eastern A	venue, E	ssex, Mar	yalnd 21221 Approximate Interval Between Onset and Death 2 - 3 LVV UM Curren
8760,	be executed icien and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	+			
P.O. Box 68	that the death certificate I ted by the attending physis detached for use as the t	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
	law requires that tha es been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	9 - 9	Completed			24a. Was an autopsy performe	prior to death?	itopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	1 Others	Check only one		
on of	Phys r this ral dii	ion: To	27. Manner of Death  1 August 25 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		ne 5 Residence 28d. Describe how	ce 6 Other (Specially occurred	cify)
Division	or Attendation of Attendation of Streetor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, stre building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
_	Hospitel 24 hours ( Funeral etely filled	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  M. D.	29c. License number D-38754		1. Date signed (Mont)	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, F Dr. Malika Waseem, 709 Eastern Bouleva	ard, Baltimore, Ma	ryland 21	1221	
	Sta Registi		31. Date filed (Month, Day, Year) 1 2006 SEP 1 1 2006	series -			

06-06496 Joseph Moyer

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28678

		- For State Registrar						ate of i	Death					Reg. No.	20		2001
Physicia edical Examii	in/	1. Decedent's Nam	e (First, Midd 3eph	le,Last) <del>Jo</del> G13	seph mn	Glynn M Me	oyer yers		oh G. M				Date of De Month August 3	0, <sup>Day</sup>	Year	0	me of Death 945 hrs
		4a. Facility Name (i 2900 blk W		_	et and nun	mber)		44	o. City, Tov Baltimo		ocation of	Death		4c. (	County of Dea	atn	
Funeral Director		5 Social Security N		6. Sex		7. Age (In yrs		hday) Yrs.	If Under	1 Year Days	If Under:	Min.		6, 19	D/YYYY) 9 For	eign	e (State or Michigan
w any		Usual Residence o 10a. State	10b. County					or Locatio								10d.	Inside City Limits  Yes 2 No
ne Maryland or 28a-f show any fied at once.	호	MS 10e, Street and Nu		omingo	)	T	isho	ming	O 10f. Zip C	nde				10a. Citize	en of What Co		X
e Mar or 28a	Director	1252 Ma:		eet i	‡4					873				USA			
with th ns 23a be noti		11. Marital Status		12.		edent Ever in	U.S.		Decedent				ify Yes or N	No- 1	4. Race - Am White, etc		ndian, Black,
b, MD 21215-0036 and 2 should be the Maryland and 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or item 23a or 28a-f shour traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Marri 3 Widowed	4 Di	vorced or D	Yes s, Give Year ates:	2 X No		1 🗌	Yes 2x	No	specify.				Specify:	Whi	
hours a		15. Decedent's E			ghest grad College (1-				s Usual Oo st of worki					16b. Kir	nd of Busines	ss/Indus	try ं
36 nin 72 than "	Completed	Elementary/Sec	ondary (0-12)	<b>'</b>   '	College (1-	-4 or 5+)		Poli	ce Of	fice	er			La	w Enfo	orce	ment
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Sof	17. Father's Name	(First, Middle	e, Last)						18	Mother's	Name (F	irst, Middle	, Maiden S	Surname)		
121 d be fil lental F larked event,	o Be	Joe Glyr	•		Print \		19	h Mailing	Address	(Street			Barn ral Route N		y or Town, St	ate, Zip	Code)
MD 2 d 2 shoul lth and M n 27 is m aumatic	۲	Andrea M												mingo		, ,	,
timore, MD 2'.  Pages   and 2 should ment of Health and M retant: If item 27 is m:		20a. Method of Dis	sposition						tion (Name				Date		ocation - City	or Tow	n, State
Baltimore, Dermit. Pages   at Department of He Important: If ite		4 Donation 5	Other S	Specify:	ternovar ire	oni State	0ak	Grove				-	/06		uka, N		
Baltimo permit. Page Department of Important: injury or otl		21. Sign, tyre of Fi	uneral Servio		nd	200	)	22. N	ame and A	ddress (					ral Ho		050
Physician		23a Part I. Enter t	he disease, o	r complicati	ons that ca	aused the dea	ath. Do n	ot enter th	e mode of	dying, s	uch as ca	rdiac or r	ox 99 espiratory a	arrest, shoc	ck, or heart	A	852 pproximate Interval etween Onset and
/Medical		failure. List or			<sup>ne.</sup> Athero	sclerot	ic ca	rdiova	scular	dis	ease						Death
Examiner		or condition result	ing in death)	Due	to (or as a	consequenc	e of):										
	ē	Sequentially list of if any, leading to it	mmediate	_	to (or as a	consequenc	e of):										
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cuted and transit				d		#1 por	ME ~	062 1	2/16/0	<del>۱۲ ۲۲</del>		-				+	
760, cate be execut physician and the burial - tra	וא∂/Medical	X UNPENDE	<u> </u>			,23a,27 <b>,</b>	per M	<u>E G860</u>	12/16/0 ), 10/3	30/ <u>0</u> 6	TT			234	. Date of deli	Verv	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	IF FEMALE: 23b. Was deceden past 12 month	ns?	the 1	Live b	nant at time o		2 Fel	tal death her <i>(Speci</i>	3 [ fy)	Ectopic	pregnan	су		Month	Day	Year
D. Bc the der by the propertion	Phy	Part II. Other sign		۹			ot resultir	ng in the u	nderlying o	cause gi	ven in Pai	rt I	23e. Di	d tobacco u	use contribute	to the	cause of death?
P.O. ires that the signed by	d by												1	Yes 2			4 Unknown
ords, w requir s been s should	ompleted		. <u>-</u> .		_			_						itopsy		to comp	y findings available letion of cause of
tal Reco cian: The law certificate has	Comi												1 ✔ Ye	erformed? es 2 No			2 No
Vital Rec ysician: The his certificate director, page	Be (	25. Was case refe examiner?		cal Hosp	ital:	Inpatient 2	□ ER/O	Outpatient		1/	of Death (		nly one) Home 5	Resider	nce 6 🗸 0	ther: Sc	ene
n of Vi ling Physi After this funeral dir	6	1 ✓ Yes 27. Manner of De	2 No ath		28a. Date			. Time of I			y at Work			be how inju	iry occurred		
ion tendin eath.	atior	1 X Natural 2 Accident		nding restigation	(IVIOIIII	n, Day, rour,				1Y	es 2						
Division of Vital Records, pital or Attending Physician: The law require ours after death.  The price of the property of the price of the present of the pre	Certification	3 Suicide 4 Homicide	6 Co	ould not be termined	28e Plac (Specify)	ce of Injury - <i>i</i>	At home,	farm, stree	et, factory,	office b	uilding, et	c. 2		n (Street ann, State)	nd Number o	r Rural I	Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 (Check only one) 2	Certifying  Medical E	xaminer:On	the basis	est of my know	vledge, de on and/or	eath occur investiga	rred at the tion, in my	time, da opinion	te and pla death oc	curred at	due to the o	ause(s) and ate and pla	d manner as ice, and due t	started. to the ca	use(s)
To Your	Mec	29b. Signature ar	nd title of cert		d manner :	stateu.			29c	License	e number				Date signed		Day, Year)
		Lance	17 M	hall	, mi	)				0.C.I	И.Е. 			Aug	ust 31, 20	006 ————	
		30. Name				use of death ( edical Exa		111 F	Penn Str	eet, B	altimore	e, MD 2	21201				
	State		onth, Day,Yea	ar)		gistrar's Sig	nature	0	. L								
Regi			JET I	1 2006		her	J.	1	all I								
DHMH 17 Rev 1	/2001						0	RIGINA	<b>L</b>								

06-06655

### Please Type or Print in Black Indelible Ink

amont Moore	1.	State of Maryland / Dep	artment of ertificate of		and Ment	al Hygi	iene	200	06 2867
Physician	R	edistrar  Decedent's Name (First, Middle,Last)	er lincale or	Death		2.	Reg Date of Death	. No	3. Time of Death
Medical Examine			ore				Month [ September		1352 hrs
	4	a. Facility Name (if not institution, give street and number)  Sinai Hospital	1	b. City, Town, Baltimore		f Death		4c. County of Dea	
Funeral	5		. last birthday)	If Under 1 \		r 24Hrs. 8	B. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Director	,	18-96-9667 1MM 2DF 25	Yrs.		Days Hours	Min.	June 2	20 /98/ Fore	ign ountry) MD
	J	Jsual Residence of Decedent	. Town or Locati			-		7	10d. Inside City Limits
ow any	1	0a State 10b. County 10c. Ci	sy, Town or Locati						1 Yes 2 No
the Maryland a or 28a-f show tified at once.	3 -	0e. Street and Number	· Souri	10f. Zip Cod	e		10g	. Citizen of What Co	untry?
th the M 23a or 2 notified		4553 Revolentown Ro	rad	2	1213	5		0	5-4)
r death with or items 23	ן מ	1. Marital Status 1. Was Decedent Ever in Armed Forces?		s Decedent of es, specify Cu				White, etc.	erican Indian, Black,
er deat		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2	No specify:			Specify: A	ni cun
ours aft	S -	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden		pation (Give k	kind of work	k done	16b, Kind of Busines	s/Industry
136 thin 72 hc ne than "na ledical Ex		Elementary/Secondary (0-12) College (1-4 or 5+)	- auring m		_		ŀ	(	1 1.
5-0036 lied within 72 hour Hygiene Lother than "natu	<u> </u>	7. Father's Name (First, Middle, Last)	1	Ceme	18.Mother:			aiden Surname)	touctor
21215. uld be filed Mental Hy marked of	2	Gregory Moone, Sr. 19a. Informant's Name/ elation ip (Type, Print)	•				met		
	2 4	9a. Informant's Name/ elatio ship (Type, Print )						er, City or Town, Sta	
e, MD I and 2 sho Health and item 27 is	-	marganet bease mother 200. Method of Disposition 20	b. Place of Dispos		cemetery,	e A	late late	20c. Location - City	ce MD ZIZ/5 or Town, State
aftimore, mit Pages I ar partment of Hee portant: If ite ury or other tr	- 1	1 VBurial 2 Cremation 3 Removal from State	crematory or oth	ner place)	ماه.	9/1	2/06	Ralth	MD MD
Baltimo permit Pag Department Important: injury or ot		4 Donation 5 Other Specify: 21. Signature of Funeral Servicy Licensee	22. N	me and Add	ress Facility	1/40	- Fur	renal Sa	envice, P. B)
<b>©</b> 825.	1	Art		11-00	5/	26	Belan	ned, so	Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.		ne mode or dy	ing, such as ca	ardiac or re	spiratory arres	st, snock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wo Due to (or as a consequence							1
		Sequentially list conditions.							
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	e of):						Ш
ted Insit	Lxa	events resulting in death) Last Due to (or as a consequence	e of):	<u> </u>					
Records, P.O. Box 68760,  The law requires that the death certificate be executed icare has been signed by the attending physician and page 2 should be detached for use as the burial - transit	edical	d. UNPENDED AMENDED							
760, cate be physici he buri		F FEMALE: 23c. If yes, outcome of pr	regnancy					23d. Date of delive	
Ox 6876(eath certificate at the drough phyrogen as the broad for use as the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen properties of the broad phyrogen phyro	clan	3b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of	dooth	tal death ther (Specify)	3 Ectopic	c pregnancy	у	Month	Day Year
Box 6876 ne death certificate the attending phy ned for use as the	nysician/iv	1 Yes 2 No 9 Unknown 9 Unknown				20110			
that the detach	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the t	underlying cau	ise given in Pa	art I.			to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the ras after death.  at Director: After this certificate has been signed by the funeral director, page 2 should be detach	g						24a. Was a	1 24b. Were	autopsy findings available
COFC	Completed					<del></del>	autops perform 1 ✓ Yes 2	ned? death	
I Re	<u></u>	25. Was case referred to medical		26.P	lace of Death	(Check onl		No 1	Yes 2 No
Vita ysicia this cer direct	9	evaminer?	✓ ER/Outpatien	3 DOA	Other <sub>4</sub>	Nursing H	Home 5 F	Residence 6 Ott	ner:
I of ling Pl	Ë	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Menth, DayYear) Sep 5, 2006	28b. Time of 1330 hrs	·	Injury at Work Yes 2	. Isi	3d, Describe ho ubject shot	ow injury occurred	<del>-</del>
Sior Attend r death ector: by the	g	Natural 5 Pending 2 Accident Investigation 28e Place of Injury - A				·	Rf Location (St	reet and Number or	Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Street	ariono, idini, sao	or, ractory, on	oo bananig, oo		or Town, Sta		
		29a. Certifier 1 Certifying Physician: To the best of my know							
To the To the Comp	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier			cense number			29d. Date signed (fi	
		101 11102A		0	.C.M.E.			September 6, 2	2006
, ,	ŀ	30. Name and address of person who completed cause of death (I							· · · · · · · · · · · · · · · · · · ·
7		Zabiullah Ali, M.D. Assistant Medical Examir		nn Street, E	Baltimore, I	MD 2120	)1		
Sta Registr		31. Date filed (Month, Day, Year) \$2. Registrar's Sign	nature						

SEPTEMBER

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 

> State Registrar

DHMH 17 Rev 1/2001

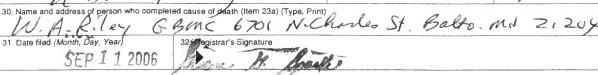
Medical

29a. Certifier

(Check only onel

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



my

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)25205

		•	For State Registrar	State of Marylar		artmen <i>rtificat</i>			nd Mei		giene Reg. No.	/ 111	06	2868	2
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  ANNA		WAKE			L castion of l	SE	Date of De Month	Day BER	6,20	906	3. Time of Death	Л
<b>)</b>	Examir Funeral Director	Ç.	5. Social Security Number 6. Sex	SPKINS HOSP	ITAL last birthday) Yrs.	BA	1471	MORE G If Under 24 Hours	= 6	Date of Bird (Month, Da G. 18		N/A		ace (State or Foreigry) MD.	n
	D	tor	Usual Residence of Decedent  10a. State 10b. County  MD . N/A		ity, Town or Lo					. 10	, 20		10	od. Inside City Limits	
	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "natural", or items 23a or 28a-f ahow avant, I're Medical Examinar must be notified at	Funeral Director	10e. Street and Number  326 JOPLIN STREET  11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	10f. Zip		21224 spanic Origin			UNIT	zen of WhatED ST	ATE	5	
-0036	thours after ntural, or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		If Yes, spec	2 <b>X</b> No	Specify:	Puerto Ric	an, etc.)		Black, Specify:	WHI'	ΓE	
Maryland 21215-0036	filed within 72 Hygiene. other than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12) 9TH  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	kind of wor DO NOT us SALI	rk doné di se retired) ES	uring most o		int Middle	RET	AIL 8		SURANCE	
aryland		To Be	BERNARD POSLUSZNY  19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address			IE SA	S			te, Zip i	Code)	
Baltimore, M	Pages 1 end 2 should nent of Heelth and Mer int: If item 27 le marke iry or other traumatic	1	MICHAEL NOWAKOWSKI  20a. Method of Disposition  1 Burial 2 Micremation 3 Re 4 Dogation 5 Other (Specify)	20b.	326 Place of Dispondence of CRI TRO CRI	sition (Nan	ne of ther place		Date		20c. Lo	cation - Cit	y or Tov	vn, State ARYLAND	
Baltir	permit. Pages Department of I Important: If its any nlury or of		21. Signature of Fineral Service ticense		22	2. Name an 5224 I	d Address EASTE	s of Facility ERN AV	CHAR E., E	RLES S	. ZE IORE,	ILER	& S	ON, INC. D 21224	
	Pnysician /Medical		23a. Partt. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deal e cause on each line.  RES F1  Due to (or as a consec						spiratory ar	rrest,			Approximate Interval Between Onset and Death Hours	
8/60,	The law requires that the death certificate be executed to the hear been signed by the ettending physicien and age 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a consecuence to (or a	Quence of):									1 week	
O. Box 6	at the death certific by the ettending p tached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3	Ectopic pro					2	23d. Date o Month		y Day Year	
Records, P.	w requires that been signed b should be deta	ted by Pr	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying ca	ause givei	n in Part I.		23e. Did to		-		e cause of death?	1
Vital Rec		e Completed	25. Was case referred to medical					26. Place of	f Dogth (C	1 Yes	rmed?	deat	e autop to com th? Yes 2	sy findings available pletion of cause of	a 
Division of VI	this in dir	ToB		ospital: 1 Inpatient 2 Inpatie	ER/Outpatier 28b. Time of Injury		8c. Injury Work	r: 4 □ Nursi	ing Home 28d		dence 6		Specity)		-
DIVIS	oital or Attanding P urs efter death. erel Diractor: After i iiled in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At h building, etc. (Speci	(fy)					City or Tow	vn, State,	)		Route Number,	
	To the Hospital within 24 hours e To the Funerel C completely filled in	Medical	29a. Certifier 1	ician: To the best of my kni ler: On the basis of examina and manner stated.	owledge, deatl ation and/or in	vestigation,	in my opi	inion, death	place, and occurred a	at the time,	date and	and manne place, and e signed (A	due to t	the cause(s)	
le	7		30. Name and address of person who cou	MEDICAL mpleted cause of death (Itel IR THE JOHN	<b>Do cto</b> m 23a) (Type,				000	1					7
u	Sta Registr		MAULIK MAJMODA 31. Date filed (Month, Day, Year) SEP 1 1 200	32. egistrar's Sign	S HOKI	NS HO	ser TA	L, 600	NORTH	WOLFE	SME	ET, BA	LTIM	OLE MARYLA	ø

28683 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month 9:05 PM September 8, 2006 John B. O'Donnell, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Catonsville 2 Fairfield Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1₩ M 2□ F 92 Yrs 24, 1914 Maryalnd Director 220-03-4257 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 □Yes 2 No Catonsville Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a or 21228 USA 2 Fairfield Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White Specify: ģ 3 Widowed 4 □ Divorced WWII "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ing most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Office Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked oth jury or other treumatic even Thomas O'Donnell Mae Brophy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James O'Donnell 2 Fairfield Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ✓ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny injury or once. 9/12/2006 New Cathedral Baltimore, MD 4 ☐ Donation 5 ☐ Øther (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Fundal Service I Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonvsille 101290 MD 21228 23a. Part1. Enter the disease shock, or heart failure. for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION NEUMONIA 2 WEEKS /Medical Due to (or as a consequence of). Examiner ONE MOUTH SWALLOWING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1□ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After th 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0040012 2006 141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

POULTON

SEP 1 1 2006

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32, Registrar's Signature

FREDERICH RO SOITE DOY, CATOLOSUILLE, MD

# Please Type or Print in Black Indelible Ink

ouglas Penningt	1	State of Maryland / D	epartment of Certificate of		d Mental	Hygiene	Reg. No 2	006 2868
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last) Douglas William Pennington				2. Date of D Month Septem	ber 2, 2006 Year	1405 1115
		4a Facility Name (if not institution, give street and number) Washington County Hospital	14	b. City, Town, or Hagerstowr		eath	4c. County of Washing	
Funeral Director		5. Social Security Number 235-96-6119 6. Sex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Day		Min	Birth(MM/DD/YYYY) 4, 1957	Birthplace (State or Foreign Country) MD
Maryland 28a-f show any d at once.		Usual Residence of Decedent	. City, Town or Locati	on				10d Inside City Limits 1 Yes 2 No
Marylan r 28a-f sk	Director	10e. Street and Number HC 72, Box 7250		10f. Zip Code 26726			10g Citizen of Wha	at Country?
	L	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 X	If Y	s Decedent of His es, specify Cubar			No- 14. Race White	- American Indian, Black, , etc.
after al",	اھ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	ed) 16a. Deceden	Yes 2 No t's Usual Occupa ost of working life	tion (Give kind		Specify:	White siness/Industry
15-0036 filed within 72 hours Hygiene d other than "natur the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Disab	led	18 Mother's N	ame (First Middl	None e, Maiden Surname)	
Orlie Maurice Pennington, Jr.  Mary Etta McGuinness  To go by a by a logal Informant's Name/Relationship (Type, Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								
Maurice & Mary Pennington HC 72, Box 7250 Scherr, WV 26726								
프로드	1	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify	crematory or off Weatherho Cemeter	ner place) 1tz Fami	11	9-7-06		nsville, WV
Baltimo permit Page Department o Important: injury or oth		21 Signature of Funeral Service Ligensee	22. N S 1	ame and Addres haeffer 1 N Mad	n Stra	et Pete	ershurg, W	IV 26847
Physician /Medical		23a. Part I Enter the disease, or emplications that caused the failure List only one cause on each line.  Immediate Cause (Final disease a Gunshot Wound to		ne mode of dying	, such as card	ac or respiratory	arrest, shock, or hea	Approximate Interval Between Onset and Death
₹xaminer		or condition resulting in death)  Due to (or as a consequence)  Sequentially list conditions,  b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		_ =				
60, e be executed ysician and burial - transit	cal Ex	events resulting in death) Last		<u> </u>				
760, Icate be expression the burial	/Medical	IF FEMALE: 23b. Was decedent pregnant in the		etal death 3	Ectopic pr	egnancy	23d. Date of Month	delivery  Day  Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/M	past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	e of death 5 Ot	her (Specify)				
P.O. res that the signed by t	ξ	Part II. Other significant conditions contributing to death bu	ut not resulting in the t	underlying cause	given in Part I		Yes 2 ✓ No 3	
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Completed					1 <b>V</b> Ye	utopsy performed? d	Vere autopsy findings available prior to completion of cause of leath?  Yes 2 No
fital   sician: is certifi lirector,	o Be (	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital 1 Inpatient	2 🗸 ER/Outpatient		Other N	ursing Home 5	Residence 6	Other:
on of Vanding Phy		27. Manner of Death  1 Natural 5 Pending  28a Date of Injury (Month, Day Year)  Sep 2, 2006	28b. Time of 1404 hrs		ury at Work? Yes 2 ✔ No	Subject s	ibe how injury occurrence hot self	ed
Divisic tal or Atters after dear al Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) College (Specify)	y - At home, farm, stre	. 1	building, etc.	or Tow	n, State)	er or Rural Route Number, City
Division To the Hospital or Attency, within 24 hours after death To the Funeral Director:	Medical Ce	29a Certifier 1 Certifying Physician: To the best of my kr (Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occu	rred at the time, of	date and place on, death occur	, and due to the dired at the time, d	cause(s) and manner late and place, and d	as started. ue to the cause(s)
To To COI	Me	29b. Signature and title of certifier	-		se number		29d Date sign	ed (Month, Day, Year)
9		30. Name and address of person who completed cause of deal  Jack Titus MD. Deputy Chief Medical Exa		nn Street, Ba	Iltimore, MI	D 21201	111210	<u></u>
	ate	31 Date filed (Month, Day, Year) 32. Registrar's		0-0-				

			For State Registrar	State of M	Marylar	nd / Depa <i>Cei</i>	artment of h	lealth and <i>Death</i>		giene 2	006	28685
	Dhusisi		1. Decedent's Name (First, Middle, I	Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Mary Catherine I						Month	08	2006	1:55 AM
	Examir	er	4a. Facility Name (If not institution, s	ilan	er)	1	4b. City, Town, o	r Location of Dea	th	4c. Co	unty of Death	
			5. Social Security Number 6	7100	Age (In vrs.	last birthday)	If Under 1 Year	20010 If Under 24 Hrs	s. 8. Date of Birt	h Ł		ace (State or Foreign
	Funeral Director		181–14–2993	1 □ M <b>2(X</b> F	85	Yrs.	Months Days	Hours Min	(Month, Da 08/15/	y, Year)	Coun	sylvania
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10	Od. Inside City Limits
	Mary B-f sh	tor	Maryland Baltimo	ore	Mi	iddle F	River					1 ☐ Yes XXNo
e 1	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	.7			10f. Zip Code			•	of What Coun	try?
)	sath w	erai	200 Kingston Roa		nt Ever in I	18 13	21220	lispanic Origin? (	Specify Ves or No		Race - America	an Indian
7	iter de	Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 2]			Was Decedent of H If Yes, specify Cubi	an, Mexican, Pue	nto Rican, etc.)	13.	Black, White,	
Mary 5-0036	eal', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1⊡Yes 2∭ZNo	Specify:		Sp	<sub>весібу:</sub> Whit	te
L)	72 hc	eted	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of we	orking	16b. Kind	of Business/Ind	lustry
Ki,	within sne. then	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Secre	DO NOT use retire tarv	a)		Nero	-Space	
2 P	Hygie Hygie other		12 17. Father's Name (First, Middle, La	st)		Deere	.cary	18. Mother's Na	ame (First, Middle,			
OUDDWSk	Jid be Jental rked c	To Be	James Kline					Anna Ma	digan			
ary	and h	-	19a. Informant's Name/Relationship				ng Address (Street					·
∑ ∑	and sealth m 27		Norman Kline (Ne	phew)	005		outh Tay.	lor Aven	ue, Esse			
·	it of H it of H if ite or ot		20a. Method of Disposition		ita (	cemetery, crei	matory`or other pla				ion - City or To	
F F	permit. Pages Depertment of Important: If II any injury or o		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lin		HC		ary Cemet					
Balti	permit. Depertrimports any inju		/ )	And the state of t		-	1407 Old	ruzdzins Eastern	ki Funera	al Hon	me, P.A.	land 21221
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	sed the dea						1, 1,41, 7, 1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SAN	Sis							Onset and Death
	/Medical Examiner		resulting in death)		as a consec	Be.						
	LAdimilei	70	Sequentially list conditions,	U	as a consec							
12	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	NUDO	skal	mia						
,	exect an and rial-tra		that initiated events resulting in death) Last	C. Due to (or	as a consec	quence of):						
1921	cate be executed oblysicien and the burial-transit	icai		d								
Box 68760	eath certifica attending ph for use as th	Physician/Med	IF FEMALE:									
Bo)	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan	n 2 ⊟Feta	al death 3	☐Ectopic pregnance☐Other (specify) _	y		230	I. Date of delive Month	ry Day Year
P.O.	that the de ad by the detached	nysic	1 □ Yes 2 ੴNo 9 □ Unknown	9□ Unknow		Jean Sc	_ Other (specify) _					
	wrequires that been signed by should be deta	by Ph	Part II. Other significent condition	s contributing to deat	h but not res	sulting in the u	nderlying cause giv	en in Part I.				e cause of death?
ord	w requir been s should	ted								res 2□N		,
ြ ခွ	e law has t	Completed							24a. Was autop perfo	an 2 osy rmed∮	4b. Were autop prior to con death?	psy findings available appletion of cause of
ie i	n: Th ficate or, pag		25. Was case referred to medical					00 81 1 8	1 ☐ Yes	2 🗷 No	1 ☐ Yes	2 <b>Y</b> No
, x	s certi	To Be	examiner?  1 Yes 2 No	Hospital: 1 Inp	atient 2	] ER/Outpatier	nt 3 DOA Ott	\or	eath (Check only only only only only only only only		Other (Specify	1)
Jo C	ding Physician: The h. h. After this certificate h: funeral director, page		27. Manner of Death	28a. Date of I (Month,		28b. Time o			28d. Describe I			,
lor	endin eath. or: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion		11,001		Yes 2 □No				
Division of Vital Records,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of	Injury - At h , etc. (Speci	nome, farm, st ify)	reet, factory, office		28f. Location (S City or Tox	Street and N vn, State)	lumber or Rura	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	(Check only 2 Medical Ex	Physician: To the be seminer: On the basi	s of examina	owledge, deat ation and/or in	h occurred at the till vestigation, in my o	me, date and place	ce, and due to the curred at the time,	cause(s) an date and pla	d manner as sta	ated. the cause(s)
	thin 2 o the	Med	one) 29b. Signature and title of certifier	and manner	Stated.		29c. Licens	se number		29d. Date s	igned (Month, L	Day, Year)
	£ ₹ 5		> 1 1.0 J	sese Mo	1		no	04575	79	a	18/11	
	.12		30. Name and address of person w	no completed cause		m 23a) (Type,	Print)	O 7076		1/	0100	
	10		Dr. Wilbur	Roese 1	9000	) Fra	nklin J	quare	Drive	Bo	uto. M	D 21237
	Sta Regist		31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign	ature	A	U			,	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Thomas Phillips, III Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month August 24, 2006 Physician/ 0634 hrs Medical Examiner **Phillips** Thomas Christopher III c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Bladensburg 5999 Emerson Street #106 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Washington Months Days Hours Director 22. 1957 49 Feb. 214-68-8162 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No a or 28a-f show tiffed at once. Prince George's Bladensburg with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 20710 5999 Emerson Street #106 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married death v 2 X No Yes White Specify 1 Yes 2 X No specify: 4 X Divorced Yes, Give Year hours after Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) nit Pages I and 2 should be filed within 72 arment of Health and Mental Hygiene. nortant: If item 27 is marked other than "ry or other traumatic event, the Medical I ry or other traumatic avent, the Medical I umatic event, the Medical Baltimore, MD 21215-0036 Construction Carpenter 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Louise Petersen Be Thomas Christopher Phillips, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) #2B, Laurel, MD 3513 Sharonwood Rd. Diana Przybysz/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 8/30/06 Alexandria, VA Metropolitan Cremator Donation 5 Other Specify 22. Name and Address of Facility 21. Signar re of Funeral Service License Davie, Approximate Interval t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and ure. List only one cause on each line /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical YUNPENDED AMENDED item#23a,27,perME,g859,9/15/06 TT ttending physician or use as the burial certificate be 23d. Date of delivery Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy Dav Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown ş Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' After this certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Fo the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient ပ 1 🗸 Yes 2 28d Describe how injury occurred 28b Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 No Natural 5 Pending within 24 hours after death To the Funeral Director: the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wilder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2006 O.C.M.E.

31 Date filed (Month, Day, Year) State Registra

Pamela Southall, MD

32. Registrar's Signature

Assistant Medical Examiner

and address of person who completed cause of death (Item 23a)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

		For State Registrar	State of Maryla	nd / Depa <i>Ce</i> a	artment of H <i>rtificate of L</i>	ealth and N Death		ene 200	6 2868	
Physicia /Medic		Decedent's Name (First, Middle, Last)     SERGEY PERTSCHU	K, SR.				2. Date of Death Month SCP+	G do	3. Time of Death	
Examino Funeral Director	er	4a. Facility Name (If not institution, give s GOOD SAMARITAN HC 5. Social Security Number 6. Sex 201-30-6880	SPITAL	s. last birthday) Yrs.	4b. City, Town, or  BALTIMO  If Under 1 Year  Months Days	DRE CTTY  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/15/	Year)	Beeth  Birthplace (State or Foreig Country)  UKRAINE	
	or	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMO	10c. C	CARNE		-			10d. Inside City Limits	
with the A la or 28a-	i Director	10e. Street and Number 2609 HARWOOD ROAD		0741412	10f. Zip Code	234	10	g. Citizen of Wha	t Country?	
72 hours after death with the Maryland Insturel', or Items 23a or 28e-f show dical Executes must be collified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☐ XNo		pecify Yes or No- p Rican, etc.)	14. Race - /	American Indian, White, etc. WHITE	
within ene. than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE		(Give	dent's Usual Occupa b kind of work done of DO NOT use retired CRVISOR	luring most of wor	king	6b. Kind of Busin		
be filed ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) GREGORY PERTSCHU	K				ne (First, Middle, M JA UNAVAI			
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ance.		MARIA PERTSCHUK/WI  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	emoval from State ST	Place of Dispo cometery cre ANDRE CEMETE	HARWOOD Distribution (Name of prainty of prainty of print) DRY 2. Name and Address 3521 LOCH	XOX 9/9	/2006 LI IE JOHNSON	Oc. Location - City		
Physician /Medical Examiner the prigi-transit	dical Examiner	23a. Part I. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect to the course on each line.  ACUTE MU  Due to (or as a consect to the course of the course	ADCARO Equence of): Clero- Equence of):		arctio diovas	n		Interval Between Conset and Death	
The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as the control of the con	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year	
v requires that been signed b should be deta	þ	Part II. Other significant conditions co End Stage I	erributing to death but not re	-	ınderlying cause give	en in Part I.	+		te to the cause of death?  Probably 4 Dunknow	
The law requate has been page 2 shoul	Completed	Chronic Obstr	uctive fu	ılmon	ary Dis	ease	24a. Was ar autopsy perform 1 Tes 2	y prior	e autopsy findings availab r to completion of cause of th? Yes 2 ☐ No	
ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 10 10 27. Manner of Death	Hospital: 1 Impatient 2	200	ome 5 Reside	nce 6 Other (	Specify)			
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 DMatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At building, etc. (Spec	Injury home, farm, st	M 1 🗆	<br Yes 2 □ No		reet and Number o	or Rural Route Number,	
To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yea									
To the within To the comple	Me	29b. Signature and title of certifier	mo		29c. License	135	29d. Date signed (Month, Day, Year)			
5	ite	30. Name and address of person who co	ompleted cause of death (It    SWA     32. Registrar's Sig	em 23a) (Type § WN nature	Print) Pene	ND 2	1334			

ORIGINAL

Sergey Pertschuk

06-06676 Please Type or Print in Black Indelible Ink Donald Pinacle State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Date of Death edent's Name (First, Middle,Last) Physician/ Month Day September 5, 2006 2200 hrs Medical Examiner Winston 4b. City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number) **Baltimore County** Timonium Stella Maris Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director 8 Country) 1**X** M 10d Inside City Limits 10c, City, Town or Location 10h County Yes 2 No or items 23a or 28a-f sho must be notified at once. and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, Was Decedent Ever in U.S. Armed Forces Never Married Married Yes f Yes, Give Year 2 X No specify Widowed Divorced "natural", δ. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) If item 27 is marked other than "her traumatic event, the Medical MD 21215-0036 of Health and Mental Hygiene Be ည 20b. Place of Disposition (Name of Baltimore, crematory or other place; Removal from State 2 Cremation 9.11.06 Baltimore Donation 5 Other Specify Voughn C. Greene Juneral Service 22. Name and Address of Facility ture of Funeral Service License 8728 Liberty Rd 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Head injuries with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial item#23a,27,28a-f,perME,g860, 10/20/06 TT P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed b be detac þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? performed? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) of Vital To the Hospital or Attending Physician: 25 Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 Other ER/Outpatient 3 After this To 1 🗸 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Natural Pending within 24 hours after death. Fnd 1/4/2006 Fnd 11:15 pm the unk Investigation Accident 28f. Location (Street and Number or Rural Route Number, City Baltimore, 19500 Oakmont Avenue 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined other-scene Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. September 6, 2006 0. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Registrar

State

Zabiullah Ali, M.D.

31. Date filed (Mo (S - 2), Year) 2006

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 1 per doc 859 9-11-06 vt.

		•	For State Registrar	State of Ma	aryland			nt of H		i Mentai H	/gier Reg. I	ZUUb	28689
E	Physicia	an	Decedent's Name (First, Middle, La	ist)						2. Date of D Month		Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gin	UIAA-	Kay	Robei		Quin	Location of De	09	$\bigcirc$	6 200€ 4c. County of Death	7:11 P M
	Examin	er	405 Riverside Dri					sex	Location of De	atri		Baltimo	re
	Funeral		Social Security Number     6.3	Sex 7. Age	e (In yrs. las	t birthday)		er 1 Year_	If Under 24 H	rs. 8. Date of 8	irth	9. Birth	place (State or Foreign
	Director		218-44-9811	1□M 2120F	59	Yrs.	Wichigh	Days	Tiouis 14	in. 12/31/	194	6 Mary	länd
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
	Many a-feh	tor	Maryland Baltimo	re	Essex	ζ.							1 ☐ Yes 2X No
	ith the	Direc	10e. Street and Number				10f. 2	ip Code			_	Citizen of What Cou	ntry?
	sath w	rall	405 Riverside Dri		5	10		2122		(01 V1		.S.A.	and testing
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event. It is Madical Exprinent must be natified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent If Armed Forces?    XXYes 2   N   If Yes, Give Year or Dates:	106	)-	_	edent of His ecify Cubar 2000	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	10-	Black, White,	etc.
8	2 hour	ted t	15. Decedent's E	ducation		i 16a. Dece	dent's Us	ual Occupa	ition		16b.		
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2	tygien her th		17. Father's Name (First, Middle, Las.	5+	[	[each	er		19 Mothor's N	lamo /First Middl			
Maryland	d be f ental } ced of c eve	To Be	William Logan Mor	_									1
ary	shoul and M s mari	F	19a. Informant's Name/Relationship			19b. Mailir	ng Addre	ss (Street a		<del>-</del>			
	and 2 ealth a n 27 I		Dawn Thiess (Daug	hter)					Drive,		-		
lore	ges 1 it of H if Itel		20a. Method of Disposition 1 ☐ Burial ②☐Cremation 3 [		сеп	-	matory o	other place	' 1	Date	1.		
Baltimore,	artmer ortent injury		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeşal Service Lice</li> </ul>		Bay			atory		11/2006	_		
Ba	Depar Impor any ir	4	1-3/2				1407	Br Old	uzdzins Easterr	ski Funer Navenue,	al Es	Home, P.A sex, Marv	iand 21221
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death.								Approximate Interval Between
	Enysician		Immediate/Cause (Final disease of condition resulting in death)	a. colon	Ca	-100	-6-					6	years
г	/Medical Examiner		rosulting in doubly					Specify: White  16b. Kind of Business/Industry  Education  Middle, Maiden Sumame)  Arguerite McNeel  Number, City or Town, State, Zip Code)  K, Maryland 21221  20c. Location - City or Town, State  Baltimore, Maryland  neral Home, P.A.  ie, Essex, Maryland 21221  Approximate interval Between Onset and Death  Conset an					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	nce of):							
	acuted Ing A	Examiner	Cause (Disease of Injury) that initiated events resulting in death) Last	c									
68760,	be ex	ai E)	Tossing III south, Last	Due to (or as	a conseque	ice or):							
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai		_ d.									
Вох	attending for use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnanc		Ectopic	pregnancy					
о П	that the death cer ed by the attendir detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown			Other (					Month	Day Year
, P.O.	res that the igned by be detact	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	nderlying	cause give	n in Part I.	23e. Did	tobacc	o use contribute to t	he cause of death?
rds	w requires been sign should be	ed by								1 [	] Yes	2 No 3 Prot	pably 4 □Unknown
eco	law re as bee	Completed								24a. Wa	ODSV	prior to co	
<u>ه</u>	sicien: The law certificate has b irector, page 2 s	Соп								per 1 Tyes			2 No
Vita	sicien certifi rector	Be c	25. Was case referred to medical examiner?	Hospital:	۰۰ ۵۵۲۲	10.		Othe		eath (Check only		- Floring 10	
of	g Phy er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		VOutpatier	_	28c. Injury	at at	28d. Describe		6 ☐Other (Special jury occurred	у)
ion	death. ctor: Aft y the fun	atio	1 Natural 5 Pending 2 Accident investigation	n	/ 1 Gai)	Injury	М	Work 1 🗆 Y	r res 2 □ No				
Division of Vital Records,	l or Atter de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not 8 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home. (Specify)	e, farm, str	eet, facto	ry, office		28f. Location City or To		and Number or Rura ate)	al Route Number,
	spital		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowle	edge, deat	h occurre	d at the tim	e, date and pla	ice, and due to the	e cause	(s) and manner as s	tated.
	To the Hospital or Atlanding Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination	n and/or in	vestigatio	n, in my op	inion, death oc	curred at the time	, date a	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				]	9c. License i つ		,		Date signed (Month,	•
'	, , \		90 Numari	nomelated as	M	201/7:-:	Dei-t'	10-	1165	3	7	101/3	-006
	611		30. Name and didress of person who	1 10 A		sa) (Туре,	rrint)	STUE	et no	m2-C/2	フド	Bultimeter	-006 MD71701
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			1 - For State Registrar	State of M	Marylan				ealth a Death	ınd M			200	б	28690
			Decedent's Name (First, Middle, Last)								2. Date of De.	ath Day	/ Yea		3. Time of Death
	Physici: /Medic		Ray	ymond Jo	hn Ro	he					Sept.		2006	. (	6:40 А м
	Examin		4a. Facility Name (If not institution, give s		er)		4b. City	Town, or	Location o	f Death		4c.	County of De	ath	
			Gilchrist Nursing				If I last	Tows	on If Under 2	24 Hzo T	0.0				e County
	Funeral		5. Social Security Number 6. Sex 219-28-9749	M 2□F 7	Age (In yrs. 73	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da				ce (State or Foreign
N.	Director		Usual Residence of Decedent		7.5						Sept.	18,	1932	Mar	yland
	land low		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d	. Inside City Limits
	Man	ţċ	Maryland Balti	more							Dund	alk			1 ☐ Yes 2 ☒ No
	th the	Directo	10e. Street and Number				10f. Z	p Code		21222		10g. Cit	izen of What	Country	/?
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	be filed within 72 hours after death with the Maryland ital Hyglene.  dother than "natural", or items 23a or 28e-f ehow event, the Madical Examiner round be notified at	Funeral	T. Maria	<ol> <li>Was Decede Armed Force</li> </ol>	s?	.S. 13.	Was Dec	dent of Hi orfy Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)		14. Race - Ar Black, Wi		
9	s afte	by F	1 Never Married 2€ Married 3 Widowed 4 Divorced	1√2 Yes 2 ( If Yes, Give Year or Date	JNo ∷ Kore	an	1 🗆 Yes	2 <b>%</b> No	Specify:				Specify:	Whi	+0
215-0036	hour		15. Decedent's Educ		3. KOL C	16a. Dece	dent's Usi	al Occupa	ation			16b. K	ind of Busines		
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2	be filed ital Hygi od other event, I	Bec	17. Father's Name (First, Middle, Last)					90 1			(First, Middle,		Sumame)		
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	is 1 and 2 should of Health and Men item 27 is marke other treumatic		Mrs. Dawn M. Pierc	e (Grando		Place of Dispo			Road		ate		ocation - City		77
0			20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta	ite	emetery, cre	matory or	other plac							
Baltimore,	t. Partmer		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of ☐ → ral Service License		Par	kwood			s of Facilit	9/5/2	2006	Ва	Telmor	е,	Maryland
Ba	permit. Page Depertment of Important: if eny injury or once.		21. Signature of the all Service License	8 /	14	- 1	uda-	Ruck	Fune	cal E	lome of				
			23a. Part1. Enter the disease, or combine shock, or heart failure. List only or	cations that caus	sed the deat	h. Do not en	7922 ter the mo	Wise de of dyin	Ave. g, such as	Dur cardiac c	ndalk, r respiratory a	Mary rrest,	land	212 A	pproximate
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× 6	eath certific ettending p I for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outco	me of pregn	ancy							23d. Date of	delivery	,
Вох	leath etter for u	clar	in the past 12 months?	1□Live birth 4□Pregnan			⊒Ectopic ⊒ Other (:	pecify)					Month		ay Year
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	res thet the de igned by the e be detached f	by P	Part II. Other significant conditions con	ntributing to deat	h but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did t	obacco	use contribute	to the	cause of death?
ğ	w require been sig should b	ed									1 🗆	Yes 2	□No 3□	Probab	oly 4 MUnknown
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Ē	ding P. h. After funera	-io	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Oate of (Month,	njury Day Year)	28b. Time o Injury	M	28c. Injun Work	yat k? Yes 2 🗍 I		28d. Describe	now inju	ry occurred		
S	Attending Physician: r death. sctor: After this certification by the funeral director, I	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injuny - At h	ome farm et			162 2 🗀		28f Location (	Street au	nd Number or	Bural F	Route Number,
Division of Vital Records,	i or Attendater death Director:	Certification:	4 ☐ Homicide determined	building	etc. (Speci	fy)	reet, racio	ry, onice			City or To				700.0 770.770
_	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier A Certifying Physical Certification Certifi												
	Ho 1 24 h Fui letely	edicai	(Check only 2 Medical Exami	ner: On the basi and manne		ation and/or in	rvestigatio	n, in my o	pinion, dea	th occurr	ed at the time,	date an	d place, and o	due to ti	he cause(s)
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	i		) youran	XVVV)	-			D:	5830	3		Sep.	Kunher	- 2	2006
î	112		30. Name and address of person who co	ompleted cause	of death (Ite	m 23a) (Type	, Print)	11	1.		r no	2/-	Cal		
4	1		ANTON J CAMU	es, no	6601	N. Cl	raris	17	245	Tho	re mi	42	09		
	Sta Regist	ate rar	31. Date filed (Month, Day Year)	2006 32. Reg	istrar's Sign	ature	Almon.	82.0							

			, roi	artment of Health and Mer	ntal Hygiene	5 28691						
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year TEMBER 7, 2006	3. Time of Death						
	/Medic	al	Michael B. Sauer  4a. Facility Name (If not institution, give street and number)		TEMBER 7, 2006							
	Examin	er	Saint Joseph Medical Center	4b. City, Town, or Location of Death Towson		timore						
	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year   If Under 24 Hrs.   8.   Months   Days   Hours   Min.   DC	Date of Birth 9. Bi (Month, Day, Year) t. 7, 1944	inhplace (State or Foreign Sountry) Maryland						
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits						
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	or 28	Olrec	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?						
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980	72 hours after death with the Maryland "naturel", or fleme 23a or 28a-f ehow rdical Endria ar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☑ No Specify:	Yes or No- nn, etc.) 14. Race - Am Black, Wh Specify:							
2-0	72 ho	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	dent's Usual Occupation  a kind of work done during most of working	16b. Kind of Busines	s/Industry						
121	- 10	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)								
d 2	filed Hygi ther		17. Father's Name (First, Middle, Last)	Attorney  18. Mother's Name (Fi	rst, Middle, Maiden Sumame)	Ш						
an		To Be	Francis Sauer, D.D.S.	Aud	drey Herman							
Maryland 21215-0036	nd 2 shullth and 27 ie m			ng Address (Street and Number or Rural Ro rnel Court Baldwin.	oute Number, City or Town, State, Maryland 21013	Zip Code)						
Je,	of Health item 27 other tr		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date matory or other place)	20c. Location - City o	r Town, State						
Ë	Pages ment of I ant: If its ury or o	1 During 2 X Compation 2 Demount from Chate										
Baltimore,	permit. Departr Imports eny inj	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ruck Towson Funeral Hotel 1050 York Road Towson, Maryland 2120.										
3	Pnysician:		23a. Part1. Enter the disease, or confiplications that ceused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition CORONARY ARTER)		spiratory arrest,	Approximate Interval Between Onset and Death						
	/Medical Examiner		Due to (or as a consequence of):  ACUTE RENAL FA	LURE								
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	s be executed sicien and (?	Examin	Cause (Disease or injury that initiated events resulting in death) Last c. CARDIOMYOPATHY  Due to (or as a consequence of):									
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О. Вох	It the death certificate be executed by the attending physicien and (Parched for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of do Month	elivery Day Year						
Vital Records, P.	es tha igned be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the HYPERTENSION	inderlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?  Probably 4 □Unknown						
900	law requir as been s 2 should	Completed	DIABETES		24a. Was an autopsy 24b. Were a	autopsy findings available completion of cause of						
Ě		Com			performed? death?	Y						
Vita	Physician: this certificated director, i	Be	25. Was case referred to medical examiner?	26. Place of Death (Cl	heck only one)							
ō		. To	1 Yes 2X No 10 Indigent 2 ER/Outpatie  27. Manyrer of Seath 28a, Dite of Injury 28b. Time		5 Residence 6 Other (Sp	ecify)						
on	Attending I or death. ector: After by the funer	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	28c. Injury at 28d. Work? 1 \[ \text{Yes} 2 \] No	occords now injury coccined							
Division	- B - C	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28f.	Location (Street and Number or F City or Town, State)	Rural Route Number,						
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal check only one)  Addical Examinar: On the basis of examination and/or in and pranner stated.	th occurred at the time, date and place, and evestigation, in my opinion, death occurred a	due to the cause(s) and manner at the time, date and place, and du	is stated. le to the cause(s)						
	To the within 2 To the complei	M	29b. Signature and time of certifier	29c. License number	29d Date signed (Mor	nth, Day, Year)						
			K. Mu Kahaii	D46356	Jep tembe	17,2006						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type									
	Cto	10	KHOSROW TABASSI M. D. 76 Ø1 OSLE  31. Date filed (Month, Day, Year)  32 Registrar's Signalure	R DRIVE TOWSON, M	ARYLAND 21204	+						
	Registr	State										

Physicia /Medic							He	g. No	28692
		Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	**	Margaret A. Spi	ttel				Septembe	er 7, 2006	2:00 P M
Examin		4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Death		4c. County of Death	1
		St. Elizabeth N 5. Social Security Number 6. Sex	ursing Home	last hirthday)	Balt:	more If Under 24 Hrs.	8 Date of Birth	9 Righ	nplace (State or Foreign
Funeral Director			<sup>M 2</sup> ₩ F 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 13.	Year) Con	untry)
D .		Usual Residence of Decedent		-					
arylar	_			y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2√2 No
Sa-f	ecto		C	atonsv			40	0.00	
with with the property of the			aniia			Ω	10		untry :
Te 23	era		2. Was Decedent Ever in U	.S. 13. V	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ncan Indian,
urs after o	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1			an, Mexican, Puerto Specify:	Rican, etc.)		o, etc. uite
72 ho natur	eted	15. Decedent's Educa	ation completed)	16a. Deced	dent's Usual Occup	ation during most of work	sina 1	6b. Kind of Business/I	ndustry
within ene. then "	Jdmo		College (1-4or 5+)	life. I	DO NOT use retired	4)		Over Home	
a the	0	17. Father's Name (First, Middle, Last)		110.		18. Mother's Nam	e (First, Middle, M		
0 = 0 = 0		Michael Beccio				Mary V	7. DelZin	igaro	
2 shou and h ie me eume			e, Print)	19b. Mailir	g Address (Street	and Number or Rur	al Route Number,	City or Town, State, Z	ip Code)
and and and and and and and and and and				108	S. Prosp	ect Avenu	ie; Cator	sville, MD	21228
Pages 1 nent of H ent: if the ury or oth		·	moval from State	arrisor	natory or other place 1 Forest	9/11	1/2006	wings Mill	s, MD
Departition Depart		21. Signature of Foreral Service Licens	Hell	22	Name and Addre Funeral H	ss of Facility Ste Iome of Ca andson Ave	erling As atonsvill enue: Cat	shton Schwa e, Inc. consville.	nb Witzke
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	cause on each line	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1ser she	PV	Asuln	Distas	se		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	1/00/-	le Div	har e		
	-	Sequentially list conditions, if any leading to immediate			Loron	1 118			<u> </u>
uted	m L	cause. Enter Underlying Cause (Disease or injury	,						
exec en an rial-tr	Еха	resulting in death) Last	Due to (or as a conseq	uence of):					
ate be nysici he bu	Ical	<b>€</b> d.		11 11 11					
	Med	IF FEMALE:							
0 0 0	ysician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 ☐ Feta	Ideath 3		<i>'</i>		23d. Date of delin Month	very Day Year
s thet			ibuting to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
quire an sig uld bi		Dementu					1 ☐ Ye	s 2 No 3 Pro	obably 4 dunknown
The law re te has bee age 2 sho	omplet						autopsy perform	ed? prior to c	copsy findings available ompletion of cause of
	0	25. Was case referred to medical				26. Place of Deat		-	2010
hysic his ce Il dire	2	1 ☐ Yes 2 ☐ No Ho	1   Inpatient 2	-	T 3L DOA	4 Nursing Ho	ome 5 Resider	nce 6 Other (Spec	ufy)
	tlon:	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe hor	w injury occurred	
ii or Atter efter dea Director d in by the	ertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
Hospita     24 hours     Funere letely fille		29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred at the tire vestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	tan 8			e number	29	d. Date signed (Month	H 2006
15		30. Name and address of person who com	poleted cause of death (Item	n 23a) (Type,		I K	n.der	O Colmor	Memoring
		31. Date filed (Month, Day, Year) SEP 1 1 200	32. Registrar's Signa	ature	ante)				
Standing Daysions: The loweron that the death conficult he death conficult he filed	within 24 hours tell death.  To the Funeral Director: After this cartificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit of properties and properties of the inportant or other treumatic events.	within 2 happened of mining in particular in the international	17. Father's Name (First, Middle, Last)  Michael Beccio  19a. Informant's Name/Relationship (Type  Margaret A. Harri  20a. Method of Disposition  1  Burial 2  Cremation 3  Rel  4  Donation 5  Other (Specify)  21. Signature of Foreral Service Licens  18 Burial 2  Cremation 3  Rel  4  Donation 5  Other (Specify)  21. Signature of Foreral Service Licens  18 Burial 2  Cremation 3  Rel  4  Donation 5  Other (Specify)  21. Signature of Foreral Service Licens  22a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  23a. Part1. Enter the disease, or complications, if any, leading to immediate Cause (Final disease or conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  25  Was decedent pregnant in the past 12 months?  11  Yes 2  No  9  Unknown  Part II. Other significant conditions continues and the past 12 months?  11  Yes 2  No  25. Was case referred to medical examiner?  26  Yes 2  No  27. Manner of Death  1  Yes 2  No  29a. Certifier  1  Yes 2  No  29b. Signature and title of certifier  30. Name and address of person who continued the past 12 months?  29b. Signature and title of certifier  30. Name and address of person who continued the past 12 months?  29b. Signature and title of certifier  30. Name and address of person who continued the person who continued the past 12 months?  29b. Signature and title of certifier  30. Name and address of person who continued the person t	17. Father's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   18.   18.   19.	17. Father's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   18. Informant's Name/Relationship (Type, Print)   19b. Mailing   19b.	To Pather's Name (First, Middle, Last)   Michael Beccio	17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Maring Address (Streat and Number or Flux Mary Name/Flationship (Type, Print)   19. Mailing Address (Streat and Number or Flux Margaret A. Harris Niece 108 S. Prospect Avent 20a. Method of Disposition (Name of Cemelatry, cremator) or order place)   20a. Method of Disposition (Name of Cemelatry, cremator) or order place)   20b. Place of Disposition (Name of Cemelatry, cremator) or order place)   20b. Place of Disposition (Name of Cemelatry, cremator) or order place)   20b. 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Place of Disposition (Name of Cemelatry)   20b. Place of Disposition (Name of Cemelat	17. Father's Name (First, Middle, Last)  Michael Beccio  19a. Informant's Name/Fallstonship (Type, Prmt)  Margaret A. Harris  19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Margaret A. Harris  19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Margaret A. Harris  19b. 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Registrar

SEPTEMBER

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SZAPIRO Physician SEPTEMBER 6 2006 310 AM STEVEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, N/A Johns Hopkins Hospita 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-76-1486 Yrs. Director 33 08/02/1973 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-1 ehow the Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3410 FIELDING ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: or items Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Peges 1 and 2 should be filed v Depertment of Heelth and Mental Hygier importent: If item 27 is marked other the any injury or other traumatic event, the page. CONSULTANT BAIL BONDS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be YURT SZAPIRO MARLENE PATEKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA PATEKA / GRANDMOTHER 3421 BIRCH HOLLOW ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO CONG. 09/08/2006 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit SOL LEVINSON & BROS., INC. matt Levinson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acute hypoxia for one hour 1 hour /Medical Due to (or as a consequence of): Examiner thrombocytopenic purpura thrombotic days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ete has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 10 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 □ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Marrier of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge ideath occurred at the fine date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 SEPTEMBER 6, 2006 30. Mime and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St., Baltmore, MD 21287 Christine Durand Johns Hopkins Hospital 31. Date filed (Month. Day, Year) 32. Registrar's Signature State Car Alex Registrar

			1 - For State Registrar	State of Marylan	-		t of Health e <i>of Deatl</i>			giene Reg. No. 200	6 28695
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	Day You	3. Time of Death
	/Medic	cal	Paul Alle			Ab Cib.	Town, or Location	of Donth	Septem	ber 9, 200	
	Examir	ier	4a. Facility Name (If not institution, give s Manor Care Health		sville			TOI Death		Baltimo	
	Funeral		Social Security Number 6. Sex		last birthday)	If Under	1 Year If Under Days Hours	or 24 Hrs.	8. Date of Birt (Month, Da	h 9. B	irthplace (State or Foreign Country)
	Director		212 38 5363 X	M 2□F 66	Yrs.	Months	Days Hours	MIII.	Sept 2	0,1939 Ma	ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl.	P	Maryland Baltimore	Mic	ldle Ri	Trow					1 ☐ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	PILO	iate itt	10f. Zip	Code			10g. Citizen of What	Country?
	th with	al D	208 Middleway Road	Apt 2D		2	21220			USA	
	r dea	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Vas Deced	lent of Hispanic C ofy Cuban, Mexic	rigin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1963	65	1 ☐ Yes 2	2∑ No Specif	y:		Specify:	white
Ş	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-1 ehow esited Examinat must be notilited at	edt	15. Decedent's Educ		16a. Deced	dent's Usua	Il Occupation			16b. Kind of Busines	ss/Industry
215	c • 👜	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. l	DO NOT us	k done during mo se retired)	ost of work		D-+h-1 -h	at a la com
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nd		Be	17. Father's Name (First, Middle, Last)  Samuel Tasker							Maiden Sumame)	
3	should be nd Mental marked c	2	19a. Informant's Name/Relationship (Ty)	na Brint)	10b Mailis	A delegan		Lizab		Miller or, City or Town, State	Zin Code)
Maryland 21215-0036	0 0 0					-					yland 21220
	Health tem 27 other tr		20a. Method of Disposition	wife 20b. F	Place of Dispo	sition /Nan	ne of		Date	20c. Location - City	
Ë	90 = 5		12 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)					ns 9/	12/2006	Balto. Co	unty, Marylan
Baltimore,	in the state of		21. Sig a ure of Fulleral Service License	The second secon	22	. Name an	d Address of Fac	ility Bo	ruzdzins	ski Funera	1 Home PA
<u>m</u>	Dep impa		14-5	2						ssex Maryl	and 21221
п			23a. Part 1. Enter the disease, or compli- shook, or heart failure. List only or	cations that odused the deat se cause on each line.	h. Do not ent	er the mode		4	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	HS	TRE	$) \circ \gamma$	Tom	H			
	/Medical Examiner			Due to (or as a conseq	uence of):	1		•			
	- 3-	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a consec	uarios of):						
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oʻ	e exectan ar lan ar urial-tı	EX	resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	cate be executed physician and the burial-transit	Ilcai									
9	sertifica ding ph	/Med	IF FEMALE:	3c. If yes, outcome of pregna	incv					024 Bass of	
Вох	eath certifi attending   I for use as	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d	I death 3	Ectopic pro				23d. Date of o Month	Day Year
o.	t the de by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
٦,	The law requires that the death certificate be executed ate been signed by the attending physician and Rage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying ca	ause given in Par	t I.	23e. Did to	obacco use contribute	to the cause of death?
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<u>~</u>		S								rmed? death 2.00 № 1 □ Y	?
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5	Phys rthis ral dii	5.	1 Yes 2 No	1 Inpatient 2	ER/Outpatien		A			dence 6 Other (Sp now injury occurred	pecify)
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	To the Hospital or Atte within 24 hours after de To the Funerel Directe completely filled in by the	Medical	(9heck only) 2 ■ Medical Examin	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or in	occurred a	at the time, date a in my opinion, de	and place, eath occur	and due to the e	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of Pertifier	and manner stated.		29c	. License number	r		29d. Date signed (Mo	nth, Dav. Year)
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	(x)		30. Name and add ass I never state	mpleted cause of death (Item	n 23a) (Type,	Print)		> 0 5	, ,	1 (U''150	R11,2006 BALTIMBRE, M
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	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	DEAK.	,			,	
	negist	IEI.	3ELTT TO	OU STEED OF THE PERSON OF	-						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Stephen C. Thompson 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1853 hrs Medical Examiner September 5, 2006 <u>Sterhen</u> 1homPson 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Ft. Washington Prince George's Ft. Washington Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or 6. Sex Funeral Age (In vrs. last birthday) Days Director 1 X M Country) 2 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n or 28a-f show Yes 2 No Tha Himore Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene annur. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Evaminor must be accepted. MD Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 312 Kenhill ave Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 8lack White, etc. Armed Forces Never Married Married 2 Yes Specify: Black f Yes, Give Year Yes 2 No specify Widowed 4 X Divorce 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Guard Securi 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Be Thompson lanne Margie 2 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Muth T. Gibson Kenhill are Baltimon Sister MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Burial 2 Cremation 3 Removal from State permit Page:
Department o
Important: I 9.11.06 South Hill Donation 5 Other Specify Signature of Funeral Service License Vaughri C. Greene funeral 8728 Liberty Rd Plandal ista m mD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 8etween Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and d. ian/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Year Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been s 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No page 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient Nursing Home 5 2 FR/Outpatient 3 DOA Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 🗸 Natural 1 Yes 2 No Director: 5 Pending hours after death Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide To the Funeral Di 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 6, 2006 30. Name and address of person who of mpleted cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SFP 1 Registrar

DHMH 17 Rev 1/2001 OCMF 2006

			1 - For Stete Registrar	state of Marylan	d / Depa <i>Cer</i>	rtment of H	ealth and Death		ene 3. No. 20 (	06	28697
			1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day V	]	3. Time of Death
	Physici /Medio		Timothy		V	Vilkens	**	Septem		ear OOC	20:30 M
	Examir		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Deat		4c. County of		
			The Johns Hon	Kins Hospi	1.1	Roltin	no Ci	4			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	(925)	. Birthpla	ace (State or Foreign
	Director		215–88–2620 <sup>1DSM</sup>	<sup>2□ F</sup> 42	Yrs.	Months Days	Hours Min.	04/19/	1964	Courte	MD
	D.		Usual Residence of Decedent	142 00							
	aryla hov	<u>_</u>	10a. State 10b. County	100. Cit	y, Town or Loc	ation				10	d. Inside City Limits
	8a-f	cto	MD	BAL	TIMORE						1 XYes 2 □ No
	or 2	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of Wha	at Count	ry?
	ath v								USA		
	er de	Funeral	11	Was Decedent Ever in U. Armed Forces?		Vas Decedent of His Yes, specify Cubai	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Black,	America White, e	
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21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow fre Medical Exactinar mast be notified at	De p	15. Decedent's Educati	Year or Dates:	160 Doord	ant's Haust Conuns	tion	144	Sh. Kind of Dunia	(1-d-	
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7	withi ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)  2 YRS		BORER			WAREHO	TICE	
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₹	iges 1 and 2 should at of Heelth and Men if Item 27 is marke or other traumatic.	F	19a. Informant's Name/Relationship (Type,		19b. Mailine	Address (Street a		Iral Route Number, (		te. Zip (	Code)
Š	and 2 seeth ar n 27 is		INEZ ZACHARY		ě .					2120	
ē	S 1 ar		20a. Method of Disposition		lace of Dispos	sition (Name of		WOODLAW Date 20	c. Location - Cit	y or Tow	n, State
ē	Pages nent of int: if it		1  Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	ovar from State	-	atory or other place	1 1		5600 O	. Don	nell St.
Baltimore,	그른분층 .		21. Signature of Funeral Service Licens	/ Mr.		EL CEMETE Name and Addres		09/06	BALTIM	ORE,	MD 21224
Ba	Depermination of the post of t		1 della low 1/4	unt.				ESLEY CHAV			
	_		23a, Peril. Enter the disease, or complicat	ions that caused the deat	n. Do not ente			AVE BAI			21231 Approximate
			23a. Part Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.	,	0 . /	,,		•		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Respir	atory	Failur	0				1 hour
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		<u>-</u>	Sequentially list conditions b.	Due to (or as a conseq		brain	injun				To hours
	is M is	ulu ulu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.1	1	50.00	4				48 hours
_6	and and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	uence of):	apres	1			-	10 hours
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m	death atte	cla	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month		y Day Year
o.	the cy by the	nys	9 Unknown	9□ Unknown							
ο.	uires that the dei signed by the a Id be detached f	by PI	Part II. Other significant conditions contrib	uting to death but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribu	te to the	cause of death?
g	n sign	q p	Cocaine abus	e hyperte	nston	, HIV		1 ☐ Yes	2□No 3[	Proba	bly 4 @ Inknown
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ā	Physicien: The la r this certificate has ral director, page 2	e C	25. Was case referred to medical				00 Plans of Pass	1 Yes 2	2No 1 🗆	Yes 2	P.□ No
5	Physicien: r this certifica ral director, I	00	examiner? 1 Yes 2 No Hosp	oital: 1 / Impatient 2	ER/Outpatient	3CI DOA Othe		ith <i>(Check only one)</i> lome 5 ☐ Residen	00 6 COthes (	C	
Division of Vital Records,	Physical controls	7. To		28a. Date of Injury	28b. Time of	28c. Injury Work	at at	28d. Describe how		Specify)	
<u>0</u>	after e fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 ∐ No				
VIS.	l or Attending Patter death. Director: After i	HC	a Could not be	28e. Place of Injury - At he building, etc. (Specification)	me, farm, stre	et, factory, office		28f. Location (Stre	et and Number o	r Rural	Route Number,
ō	al or A s after il Dire	Certification:	4 - Homiciae	building, etc. (Specin)	′)			City or Town,	State)		
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physici	an: To the best of my kno	wledge, death	occurred at the time	e, date and place	, and due to the cau	se(s) and manne	er as sta	ted.
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Exeminer: one)	On the basis of examina and manner stated.	tion and/or invi	estigation, in my op	inion, death occu	rred at the time, date	and place, and	due to t	he cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b.	Ž	29b. Signature and attle of contifier			29c. License			I. Date signed (A		•
)	-		1 th a	m.o.		RE	5-000	3 5-	stent .	. ^7	7000
	7		30. Name and address of person who comp	leted cause of death (Item	23a) (Type, F	Print)		120	VINTOCE		- 4000
			Santosh Commen,	M. D. leted cause of death (Item	Wolf	e Street	+ Balti	more m.	aculana	17	(287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	0-	,		1 - 421		
	Registr	ar	25 L T T 501	The state of	St. L	mark)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 19a per inf 8859 9-13-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2006 28698 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2006 0948 TRI CI 10 WILLIS entember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital B Bal Harbor If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. enter 8. Date of Birth (Month, Day, Year) July 31, 1969 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1□ M 2□F MO Director 217-02-0058 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other then "neturel", or items 23a or 28e-f show other treumstic event, the Madical Expression must be notified at 1 Fres 2 No Bultmore MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Road SK Hollins 21230 3023 renuly Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other then "neturel", or Iter The can 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ane given 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L. Willis 2 homa Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3023 Hollins Ferry Read Baltmore MD 21250 MO then If item 27 <del>Willi</del> Gloria 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Department Importent: If any injury or once. 06 \* 4 ☐ Donation 5 ☐ Other (Specify) 1 view Chemoter 22. Name and Address of Facility 21. Signature of Funera Service Licensee Semice Fungeral. But there new 21206 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxia Physician disease or condition resulting in death) 0 /Medical as a consequence of). **Examiner** Res Sequentially list conditions, many leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to for as a consequence Examiner for use as the burial-transit D. Colone Due to (or as a consequence of) as porme P.O. Box 68760, Physician/Medical Cardiamyopa IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  $\int dx \mathcal{L} \mathcal{I}_{\mathcal{K}} \mathcal{L}_{\mathcal{K}} \mathcal{L}_{\mathcal{K}} \mathcal{L}_{\mathcal{K}} \mathcal{L}_{\mathcal{K}} \mathcal{L}_{\mathcal{K}}$ Division of Vital Records, 9 the funeral director, page 2 should be Hypertension 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No this certificate Diabete Sarcoidasis 2 DNo 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔽 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 MO ZS 000 10 30. Name and address of person who comp feted cause of death (Item 23a) (Type, Print) Hanover SUN Baltimore. Manyland 21225

DHMH 17 Rev 1/2001

State Registrar XIAOGU

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Street.

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32. Registrar's Signature

			1 - For State Registrar	State of Maryland		rtment of H			ene g. No. 2006	28699
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Vincent	В.	Woytow	witz, S	2. Date of Death Month Septem	Day Year ber 5,200	3. Time of Death 5 8:00 A M
1 18	Examin		4a. Facility Name ( <i>If not institution, give str</i> Genesis Heritage Me			4b. City, Town, or Dunda	alk		4c. County of Dea	Baltimore
V.	Funeral Director		5. Social Security Number  213-10-5782  Usuat Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year) Co	thplace (State or Foreign ountry) aryland
	Maryland -f ehow	tor	10a. State 10b. County  Maryland Balti		, Town or Lo	cation		Dunda1	k	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	rai	3442 Yorkway					1222	United St	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow or other traumatic event, the Mariteal Examinar must be notified at	by Funerai	11. Marital Status	. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	"	Vas Decedent of His f Yes, specify Cubar □ Yes 2⊠ No	spanic Origin? n, Mexican, Put Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
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	ed with	Com	12 Years	30110g8 (1 401 51)		Machi	inist		Stee1	
Maryland	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last)  George Woytowitz				18. Mother's N	ame (First, Middle, M	aiden Sumame) [	Jkn.
Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type Patricia Woytowit			g Addres <i>s (Str</i> eet a ! Yorkway		Rural Route Number, lk, Maryla		Zip Code)
Baltimore,	ages 1 a ent of Hea et: If Item y or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☑ Other (Specify)	20b. Pla	metery, cren	sition (Name of natory or other place 1 Mem. Go		Date 2	Oc. Location - City or	
Baltii	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any Injury or other tra once.		21. Signiture Aneral Service See	Juli 1	22 D	. Name and Address ouda-Ruck	s of Facility Funera	1 Home of Dundalk, N	Dundalk, I	
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)	To th withir To th comp	Me	29b. Signate and title of certifier	Tinter 1	UD	29c. License	201	00	d. Date signed (Mont	
1	7	, iii	30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I	Print)	IXa	Dirak	ace No	21222
	Sta Registr		31. Date filed (Mortin, Day, Year) 1 20	32. Registrar's Signatu	ITO I	granks	1 AC	500000	ws 19	

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Tasha Marie You	•	St - For State	ate of Maryla		artment o		l Mental	Hygiene	0	006 0076		
Physicial		Registrar 1. Decedent's Name (First, Midd	e.Last)		- Cale O	Deau		2. Date of Dea	Reg. No	JU6 28/L		
Medical Examin	11/		Young					Month	Day Year er 1, 2006	1016 hrs		
para la la la la la la la la la la la la la		4a. Facility Name (if not institution		ımber)		4b. City, Town, or L	ocation of De		4c. County of	Death		
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		rth (MM/DD/YYYY)	9. Birthplace (State or DC		
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		Usual Residence of Decedent										
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ath wi	Funera	1 Never Married 2 M				s Decedent of Hisp es, specify Cuban,			o- 14. Race - White,	American Indian, Black, etc.		
ter de			1 Yes orced If Yes, Give Ye	2 X No	1	Yes 2XX No	specify:		Specify:	Black		
urs afi tural	핡	15. Decedent's Education (Spe	or Dates:		16a. Deceder	it's Usual Occupation		of work done	16b. Kind of Busi	ness/Industry		
n "na al Ex	ompleted	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during m	ost of working life. I	DO NOT use	retired)				
036 ithin ne.	립	12th			Ι	omestic			Priv	ate		
21215-0036 und be filed within 7 Mental Hygiene. marked other than	91	17. Father's Name (First, Middle				1			Maiden Surname)			
121 dbe fi ental arked vent,	Be	Thaddeus Crud						endia You				
D 2 Shoul and M 7 is m	-1	19a. Informant's Name/Relations							mber, City or Town,			
, MD and 2 sho ealth and em 27 is raumat	- 1	Robin Young – S  20a Method of Disposition	sister	20b.		ition (Name of cem		Date Date	ington, 1	Dity or Town, State		
Baltimore, permit Pages I an Department of the Important: If the		1 Burial 2 Cremation	n 3 Removal f	rom State	crematory or ot	her place)						
t Pag t Pag tment rtant:	-	4 Donation 5 Other S	pecify:	Re				9/12/2006	Clinto	n, Maryland		
Bal permi Depar Impo	-	21. Signature of Funeral Service			4.	lame and Address	6.3		neral Se			
Physician	+			caused the deat	h. Do not enter t	01 CLeve. the mode of dving, s	Land Av	venue; Ri	verdale,	MD 20737 t Approximate Interval		
/Medical		failure. List only one cause on each line.  Between Onse										
Examiner	1	Immediate Cause (Final disease or condition resulting in death)		ensive ca a consequence		lar disease	9			- Dodan		
· /		Sequentially list conditions,	b									
	Examiner	if any, leading to immediate	Due to (or as	a consequence	of):							
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
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0, s be execut sician and burial - tra	edical	X UNPENDED	AMENDED	#23a.PTT	. 27. nerMF	. g863, 1/5	5/07 TT					
68760, pertificate be right physic se as the burn	₩.	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pre	gnancy		_		23d. Date of de	elivery		
certif	sician/M	past 12 months?	LILLING	ointh nant at time of d	tooth -	tal death 3	Ectopic pre	gnancy	Month	Day Year		
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ision of Vital Records, P.O. Box 6876( Attending Physician: The law requires that the death certificate releath retor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the b	۵.	Part II. Other significant condit	ions contributing t	o death but not	resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribi	ute to the cause of death?		
ires that the signed by t	d by	HIV						1Ye	s 2 No 3	Probably 4 V Unknown		
rds requi	lete							24a. Was auto		ere autopsy findings available or to completion of cause of		
eco he law ite has	Completed			•					ormed? de	ath?  Yes 2 No		
Division of Vital Records, tal or Attending Physician: The law requirs after death all Director: After this certificate has been set in by the funeral director, page 2 should		25. Was case referred to medica				26.Place	of Death (Che		2 10 1	7 Tes 2 10		
Vita ysicia his ce direc	o Be	examiner?	Hospital: 1	Inpatient 2	✓ ER/Outpatient	3 DOA	Other: Nu	rsing Home 5	Residence 6	Other:		
ding Phy After th	洁	27. Manner of Death	28a. Date (Mont	of Injury h, Day,Year)	28b. Time of	njury 28c. Injury	at Work?	28d. Describe	how injury occurred	1		
ion tendi eath lor: /	탏	1 X Natural 5 Pen		.,,,		1 Y	es 2 No					
VIS or At fifter d Direct in by	ertification:			ce of Injury - At I	home, farm, stre	et, factory, office bu	uilding, etc.	28f. Location (		or Rural Route Number, City		
Di pital ours a	Set	4 Homicide	rmined (Specify	)				OI TOWII,				
		Tondon only	hysician: To the be		_							
To th within To th	Medical	2 💌	miner:On the basis and manner		and/or investiga			o at the time, date				
	2	29b. Signature and title of certific	er /			29c. License O.C.M			1	(Month, Day, Year)		
		Panule Fourth	2(1, NO)			0.C.IV	/I.C.		September 2	1, 2006		
4		30. Name and address of persor Pamela Southall, MD	Assistant Me		,	Penn Street, Ba	altimore, M	1D 21201				
Sta		31. Date filed (Month, Day, Year) SEP 1	1 2006 32.R	edistr <b>ar</b> 's Signa	iture	adi			<u></u>			
Registr DHMH 17 Rev 1/20		OLI 1	T 7000	TELLE I	ORIGINA					<del></del>		
A 21 1 20 1/20	- 1				CHICHA	_						

State of Maryland / Department of Health and Mental Hygien ? 106 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 7, 2006 **Physician** EARLE LEMUEL YOUNGER 5:30 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE MANOR CARE TOWSON TOWSON Year If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Yrs. 215-26-5968 5/13/1930 MARYLAND Director 76 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir than "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director N/A BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 6026 APT. C GREENMEADOW PARKWAY 21209 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSE PAINTER HOUSE PAINTING 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Pages 1 and 2 should be RAYMOND YOUNGER ESTHER POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 I JOYCE YOUNGER/WIFE 6026 APT. C GREENMEADOW PARKWAY BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
eny injury or oti
once. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 9/12/2006 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) CATONSVILLE. MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, imma in cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy DEMENTI 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Voluming Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending after death. 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funaral D Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-8012849 9-8-00 Cla 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) OSLER Dr. FOUSON MD 21204 32, Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 1 1 2006

			1 - For Amend #	State of Marylan 10b-d&12 PerFH (	d / Departme 3859 <b>Certific</b> a	ent of Health and of Death	and Me	ntal Hygi	ene g. No. 2006	28702
			Decedent's Name (First, Middle,		-			. Date of Death	1	3. Time of Death
	Physicia		Norman	Cazmer	Zau	ORSKI		SEP+.	Day Year	536pm
4	/Medic Examin		4a. Facility Name (If not institutjog,	give street and number)	4b. Ci	ty, Town, or Location			4c. County of Dear	h
	LXamm	C1	BaltimoreVA	Medical Cen	ter t	300 Hin	ore	•		
	Funeral			3. Sex 7. Age (In yrs. i	last birthday) If Und			Date of Birth (Month, Day,	9. Bird	hptace (State or Foreign
	Director		217-36-4677	108M 2□F 69	Yrs. Month	ns Days Hours	Min.	April 29	1937 Mar	yland
	ס		Usual Residence of Decedent							
	how		10a. State 10b. County		y, Town or Location					10d. Inside City Limits  152⊻es 22√No
	e-f-	Ş	MO M	MMONE CITY A	3AZ TIMO	Dunda	alk			
	or 28	lre	10e. Street and Number		10f.	Zip Code		10	og. Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28e-f ehow rmust by nutified at	Funeral Director	7950 ST BY			2122	2		US	
	dea	ner	11. Marital Status	12. Was Decedent Ever 1956 Armed Forces?	S. 13. Was De	cedent of Hispanic Or pecify Cuban, Mexica	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
ထ္	or it	五	1 ☐ Never Married 2 ☐ Marrie	d   1∭XYes 2∐No L96	o2. I	2 No Specify	<i>/</i> :		Specify: w	412
5-003	hours after tural', or ite	d by	3 Widowed 4 Divorced	Year or Dates:	455					
	72 P	Completed	15. Decedent's (Specify only highest		16a. Decedent's U (Give kind of life. DO NO	work done during mo:	st of working	,	16b. Kind of Business	rindustry
2121	within ene. then "	g D	Elementary/Secondary (0-12)	College (1-4or 5+)	Machin				National	Wire Co.
N N	be filed within 72 hours after dei tal Hygiene. d other then "netural", or items event, the Medical Examinal m		12 Years 17. Father's Name (First, Middle, L	ast)	Machin		ner's Name (	First, Middle, M	Maiden Sumame)	
land	ould be f Mental I arked of	Be	John Walter				,		A. Gawlik	
Ž	should be nd Mental marked imatic ev	우	19a. Informant's Name/Relationshi		19h Mailing Addr	ess (Street and Numb	her or Rural I	Route Number	City or Town, State,	Zip Code)
Maryl	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic a DRGs.		Mrs. Linda J.			t. Bridget			lk, Maryla	
a)	1 and Healt Pm 2 ther		20a. Method of Disposition	20b. P	_  Place of Disposition (i	Name of	Da	te 2	20c. Location - City or	Town, State
Baltimore,	ages if it		1 Burial 2 ☐ Cremation	3 Li Hemovai from State	emetery crematory		9/9/2	006	Baltimore	, Maryland
Ħ	t. Part rtant rtant		4 Donation 5 Other (Sp. 21. Signature of Figure 12.		k Lawn Ce					
Bal	Depa mpo my in		21. Signature of Pararai Service L	Consee Manual Ma					Dundalk, I	
	20204		220 Point Fator the disease or o	complications that caused the deat	7922	Wise Ave.	Dune s cardiac or	dalk, M	aryland 2	21222 Approximate
Н			shock, or heart failure. List of	nty one cause on each line.	n. Do not antar the h	node of dying, such a	3 cardiac or	rospilatory arre	, , ,	Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	- a PANCATIC	CANCER	WITH LIVE	en Mei	MENSIS		1-onth
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	,					1 00/-
	)	_	Sequentially list conditions,	b. O-ASTROINTE  Due to (or as a conseq		FUNGE				lucer
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice or).					
	and P-tran	хап	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
8760,	Attanding Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	calE			•					
	physicate s the			d						
Box 6	ding	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Date of de	livery
B	atten for u	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 □Ectopi	c pregnancy (specify)			Month	Day Year
о. О	he de ched	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		(		011		
	res that the death certific Igned by the attending p be detached for use as	モ	Part II. Other significant condition	ns contributing to death but not res	ulting in the underlyin	ng cause given in Part	t I.	23e. Did tob	acco use contribute t	o the cause of death?
ds	sign d be	d by						1 🗆 Ye	s 2□No 35XP	robably 4 Unknown
Š	w require	ete						24a. Was a	n 24b. Were a	utopsy findings available
Records,	has pe 2	Completed						autops perform	ned?   death?	utopsy findings available completion of cause of
<u>=</u>	ysician: The is certificate he director, page									s 2□ No
Vital	sicial certii recto	Be	25. Was case referred to medicat examiner?	Hospital:	1500	Other		(Check only on	e) ence 6 □Other (Spe	
ō	Phys raidi raidi	5	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Injury at Work?			ow injury occurred	эспу)
o	ding h. Afte fune	tou	1 Natural 5 Pending 2 Accident investig	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐	□No			
S	deat deat ctor: y the	fica	3 Suicide 6 Could n	ot be 399 Place of lowny - At h	ome, farm, street, fac	ctory, office	21		reet and Number or F	lural Route Number,
Division of	after Dire	Certification	4 Homicide determi	building, etc. (Special		•		City or Towr	n, State)	
_	To the Hospital or Attanding is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, death occur	red at the time, date a	and place, ar	nd due to the ca	ause(s) and manner a	s stated.
	Me Ho	Medical	(Check only 2 Medical E	xaminer: On the basis of examina and manner stated.	ation and/or investiga	tion, in my opinion, de	eath occurre	d at the time, d	ate and ptace, and du	e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. License number			9d. Date signed (Mon	
	_		1 /	MO		17530	Y		SOFT 4	12006
	.15	1	30. Name and address of person v	who completed cause of death (Iter	m 23a) (Type, Print)				0	<i>/</i>
6	1	1		STEPHENTH	anjuerno	10 N-G	REEKE	FST	BAZATORE	np 21201
-		ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature					
	Regist	rar	SEP 11	2006	The Annah.	,				

			For State Registrar	State of N	/laryland / I	Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M		iene eg. No.	2006	28703
		4	1. Decedent's Name (First, Middle, Las	1)							2. Date of Deat Month	Day	Year	3. Time of Death
	Physici /Medic		Sol Agler								8- 21-	06		5:15 A M
1	Examir	er	4a. Facility Name (If not institution, give				1		Location of	of Death			County of Death	
	- A -		Potomac Valley No. 5. Social Security Number 6. Se		ome Age (In yrs. last bi	irthday)	Rock		.e If Under	24 Hrs.	8 Date of Birth		Iontgome	place (State or Foreign
Bee.	Funeral Director		120-03-3902	É M 2□ F	89	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, 2-09-19	Year)	Cou	York
	D C		Usual Residence of Decedent											
	anylar ehow	5	10a. State 10b. County	- 2077	10c. City, Tow		pring							10d. Inside City Limits 1X Yes 2 ☐ No
	the M	ecto	MD Montgome		31140		10f. Zip	Code			1	Og Citis	en of What Cou	
	with Ba or	D.	15107 Interlachen	Drive #2	210			0906	•			S.		iniy:
Maryland 21215-0036	be tiled within 72 hours atter death with the Maryland nat Hygiene. od other than "natural", or Itame 23a or 28e-1 ehow event, the Medical Exeminar must be motified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 N Yes 2 If If Yes, Give Year or Dates	nt Ever in U.S. s? ]No		Was Deceded Yes, special		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ocity Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: Whit	etc.
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad		16a	. Dece	dent's Usual kind of worl	l Occupa	tion	of worki	na	16b. Kir	d of Business/Ir	ndustry
21	nen hen	Completed by	Elementary/Secondary (0-12)	College (1-4o	or 5+)	life.	DO NOT us	e retired)	_				_	
2	Hygier Hygier Ther ti		12th 17. Father's Name (First, Middle, Last)		Ke	етос	ation	Spe			(First, Middle, I	Maiden :	Govern	ment
and	d 2 should be tiled within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mar	To Be	Joseph Agler						Fanı		Levitan		Jumamey	
ary	shoul and Mark mark umati	1	19a. Informant's Name/Relationship (7	ype, Print)	198	b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Number	City or	Town, State, Zij	c Code)
Z	and 2		Jeffrey Agler/ So	a					Blvd	. Bet	thesda,	MD 2	20817	
Baltimore,	Tof H		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from Sta	20b. Place of cemete	of Dispo ery, crer	sition (Nam natory or oti	e of her place	9)		ate	20c. Lo	cation - City or T	own, State
ţ	t. Pag		4 ☐ Donation 5 ☐ Other (Specify	)	Judea						The second second		y, MD	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked eny Injury or other traumatic e-		21. Signature of Fun Hall ervice Licens	188							e Rockv			Direction 852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caus one cause on each	sed the death. Do line.	not ent	er the mode	of dying	, such as	cardiac d	r respiratory arre	est,		Approximate Interval 8etween Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ral Infa		ion							
	Examiner				as a consequence	of):								
47	7.7	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	15 a Consequence	ol).								
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c										
30,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or a	as a consequence	of):								
8760,	cate b	dical		d				_				-		
.O. Box 6	he death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		Ectopic pre Other (spe					2	3d. Date of deliv Month	ery Day Year
Vital Records, P.	uires that the signed by Id be detacted	by	Part II. Other significant conditions of Diabetes Mel.	ntributing to death Litus Typ	but not resulting e II	in the u	nderlying ca	use give	n in Part I.		23e. Did tob			he cause of death?
Ö	s been s been	Completed									24a. Was a		24b. Were auto	opsy findings available
æ	: The lav icate has ; page 2	E									autops perform	y ned? No	prior to co death? 1 ☐ Yes	mpletion of cause of
ital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			Zeg
of V	Physiclen: this certificanal director,	٥	1 ☐ Yes 2 🔀 No	Hospital: 1 🔲 Inpa		utpatier			4 K 14u		ne 5 ☐ Reside			fy)
n	ding P. h. Atter I tunera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, L	njury 28b. Day Year)	Time of Injury	f 28	Bc. Injury Work	at ? ∕es 2∐l		28d. Describe ho	w injury	occurred	
Division	r Attending er death. rector: Atter by the tune	ficat	2 Accident investigation 3 Suicide 6 Could not be		Injury - At home, fo	arm. str			9S 2[]		28f. Location (St.	reet and	Number or Run	al Route Number.
Š	F 6 F 5	Certification:	4 Homicide determined	building,	etc. (Specify)	w.,, 0,,	cot, lactory,	Omoo			City or Town	, State)		ar riodio ridingor,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the be- liner: On the basis and manner	of examination as	je, deatl nd/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the ca ed at the time, da	use(s) ate and	and manner as s place, and due t	stated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (Month,	Day, Year)
	10		Burgh	Con				D239	58			8-	-21-06	
	l		30. Name and address of person who o	completed cause o	f death (Item 23a)	(Туре,								
	*		Burt Feldman, M					lvd.	Silv	er S	Spring,	MD 2	20906	
200	Sta Registi		31. Date filed (Month, Day, Xear) AUG 25 20	106 Har	strar's Signature	April	wie							

DHMH 17 Rev 1/2001

06-06347

# Amended Item 5 per F.D. 09/01/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

George Edward Ashwell

9		1- For State Certificate of Death Registrar Certificate of Death	Wienia i i y	Reg	. No. 206	06 2870
Physici	an/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 1952 hrs
ledical Exami	ner	George Edward Ashwell  4a Facility Name (if not institution, give street and number)  4b. City, Town, or Lo		August 24,	2006 4c. County of Dear	
		Carroll Hospital Center Westminister			Carroll	
Funeral Director		215 58 3212 6. Sex 1. Age (In yrs. last birthday) Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth  July 1	Fore	irthplace (State or ign ountry)
any	}	Usual Residence of Decedent  10a State				10d. Inside City Limits
m .	ō	MD Carroll Westminster				1 Yes 2 X No
Maryland r 28a-f sho ed at once.	Director	10e. Street and Number 10f. Zip Code		10g	j. Citizen of What Co	untry?
ith the		656 Alpine Drive 211.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa		cify Ves or No-	USA	rican Indian, Black,
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygerner is a fired within 72 hours after death with the Maryland is manked other than "natural", or items 23a or 28a-15ho natic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year  1 Yes 2 No	Mexican, Puerto R		White, etc.	White
nours a natura	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life. D			16b. Kind of Business	/Industry
36 iin 72 }  han "i	omplete	Elementary/Secondary (0-12)  College (1-4 or 5+)  Physical Educa:			School S	Svetem
5-00; ed with tygiene other t	Com		B.Mother's Name (I			Dy Sceni
21215-0036 buld be filed within 72 Mental Hygiene. marked other than '	å	Dale Ashwell		Griffit		
ore, MD 21215-00.  s I and 2 should be filed with of Health and Mental Hygene Ifiten 27 is marked other the traumatic event, the Mec	Ţ	19a. Informant's Name/Relationship (Type, Print)  Joanne Ashwell/wife  19b. Mailing Address (Street and Street			•	e, Zip Code) 1157
nore, MD 2 ages I and 2 shou nt of Health and M it: If item 27 is n other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of ceme			20c. Location - City o	
MOF Pages ent of int: If		1 Burial 2 remation 3 Removal from State 4 Donation 5 Other Specify:  Carroll Cremation	, Inc 8/	28/2006	Hampste	ead, MD
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other it		22. Name and Address o				A
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so	gton Roa	d West	minster, N	21157 Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Coronary Artery Thrombosis			,	Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	l l	Sequentially list conditions, if any, leading to immediate b. Focal Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated				
uted d ansit		events resulting in death) Last events resulting in death) Last d.				
760,  cate be executed  physician and the burial - transit	edical	UNPENDED AMENDED				
68760, certificate be nding physici se as the buri	≥	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delive	
x 68 h certif tending	iciar	4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnand	су	Month	Day Year
Records, P.O. Box 68' The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	on to Book I	22- Didtah		the second of death?
ires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv  Dilated cardiomegaly with left ventricular hypertrophy	ven in Part I.			o the cause of death?
ords, F w requires s been sign should be	Completed			24a. Was an		utopsy findings available
Recor The law icate has b	dm			autopsy perform	ned? death?	process
	Be Cc		of Death (Check or			2 140
ight Bis Sign	To B	V Yes Z No			esidence 6 Othe	er:
n of Notation of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office of the office office of the of		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury 1 Ye	es 2 No	8d. Describe ho	w injury occurred	Į.
riSior r Attencer death irector:	ertification:	2 Accident Investigation 28e Place of Injury - At home farm street, factory office bui		8f. Location (Str	reet and Number or R	tural Route Number, City
Divis pital or At ours after d teral Direc	ertit	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ite)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	cal C	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one) A Medical Examiner: On the basis of examination and/or investigation, in my opinion of				
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated  29b. Senature and title of certifier  29c. License			29d. Date signed (M	
IN-IL	_	0.C.M			August 25, 2006	
30		30. Name and address of person who completed cause of death (Item 23a)				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201			
S Regis	tate trar					
		The state of the s				

s 50 🐇		1 - For Stata Registra MEND#23a-PT  1. Decedent's Name (First, Middle,			Certificate of		2. Date of De			3. Time of Dear	th
Physicia /Medic		Jerome Brod	ie				Aug	14, Day 20	06 ear	7:50P	М
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death		4c. Count	y of Death		
		Potomac Valley			Rockvi		T		tgome		
Funeral Director		5. Social Security Number 579–14–8487 Usual Residence of Decedent	5. Sex 7. Age 1 ☑ M 2 ☐ F 8	(In yrs. last bir	Yrs. If Under 1 Year Months Days		8. Date of Bir (Month, Da 12-27-	th ay, Year) ·1920	9. Birthp Cour New	lace (State or For htry) York	eign
natural', or itama 23a or 28a-f show dical Examinar must be notified at		10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside City Lin	nits
ns 23e or 28e-f show must be notified at	ctor	MD Montgo	omery	Bethes	da					1X Yes 2 □	No
or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
238	rai	7001 Buxton Term			2081			U.S.	Α.		
aminar	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? d 1 X Yes 2 □ N If Yes, Give Year or Dates: W	lo	13. Was Decedent of H If Yes, specify Cub  1 ☐ Yes 2 No		ecify Yes or No Rican, etc.)	5- 14. Rai Bla Specil	ce - Americ .ck, White, fv:		
GIE		15. Decedent's			Decedent's Usual Occup	nation		16b. Kind of 8		ite	
Medical Ex	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5-		(Give kind of work done life. DO NOT use retire	during most of work d)	ing	TOD. TAING OF E	431110334111	zustry	
2	Completed	Clementary/Secondary (0-12)	2+		eal Estate l	Developer		Real Es	state		
fraumatic event, the Me	Be (	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	e (First, Middle	, Maiden Sumai	пе)		
atic	10	Harry Brodie					odie				
er traum		19a. Informant's Name/Relationship Stephan Brodie			. Mailing Address (Street 001 Buxton 7					Code)	
njury or other traumatic event, the		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		cemetei	Disposition (Name of ry, crematory or other pla	ce)	Date	20c. Location			
ndur a	1	21. Signature of Funeral Service Lie		King I	David Memori 22. Nam <b>Banizar</b>			Falls (			-
any r		- Line			1170 Rocky						
ician		23a. Part1. Enter the disease, or construction of the construction	omplications that caused nly one cause on each line a.	the death. Do n		ng, such as cardiac				Approximate Interval Between Onset and Death	
dical niner		resulting in death)	Due to (or is a	consequence	Renal	Fai	luve	,		6 Mm	this
ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):						
the burial-transit	ical Exa	resulting in death) Last	Due to (or as a	consequence	•						
as the		IF FEMALE:	dFall	ite to i	литие			I			
iched for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у			ite of delive onth	ry Day Year	
peq	۾	Part II. Other significant condition: Advanced demei		t not resulting in	the underlying cause given	ven in Part I.	23e. Did t			e cause of death?	
, page 2 sho	Completed						24a. Was autoj perfo	rmed?	death?	osy findings availanted to the control of cause 2 No	able of
rector	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death					-
neral di	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		tpatient 3 DOA Oth	y at		dence 6 Oth		')	
y the fu	Certification:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	t be Zan Blace of Injury	10		Yes 2 □No	28f. Location (	Street and Numb	ORT OT PUTA	Route Number	
lled in b	Certi	4 Homicide determine	building, etc.	. (Specify)			City or To	νn, State)			
To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination an	, death occurred at the tird/or investigation, in my d	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)	
	ž	29b. Signature and white of certifler  SESSY  30. Name and address of person wh  SHYED M. E	Mach	MD	29c. Licens	6243	5	29d. Date signe	d (Month)	Day, Year)	-7
3	1	30. Name and address of person wh	no completed cause of de	ath (Item 23a) (	Type, Print)	4 4 0	0	,			

Registrar

AUG 25 2006 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200628706 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 26 2006 ar Beckley 1:22 P HI1da Dolores /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's 26152 Sandy Court Mechanicsville 7. Age (In yrs. last birthday)

SQ

Months Days Hours Min. Mayouth Day3 ear) 1948 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Massachusetts Director 553-80-4526 Usual Residence of Decedent 10c. City, Town or Location Mechanicsville 10b. County
St. Mary's 10a. State 10d. Inside City Limits r than "natural", or ferms 23a or 28a-f show the Mudical Expoliner rount be rigitled at Maryland 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20659 26152 Sandy Ct. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygtene.
smit if item 27 le marked other than "natural", or flems 23, and it if or other traumatic event, in a Mental Esse, infratural any or other traumatic event, in a Mental Esse, infratural and the second sec 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inventory Specialist Wholesale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Mederios ဥ Armand Leroux 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26152 Sandy Ct., Mechanicsville, MD 20659 Todd R. Beckley/Husband 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Queen of Peace Cem. 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or once. August 31, Helen, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice ee P.O. Box 128, Charlotte Hall, Maryland 20622 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Medical Certification; To Be Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □ Ectopic pregnancy signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☐ Xe Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this Director: After the in by the funeral 27. Manner of De vin 1.-☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury Division 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 703 cje 32. Pregistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar		aryland / Depa	artment of I rtificate of		Re	g. No. $2006$	
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)     John Irving     4a. Facility Name (If not institution, give seconds)	Bucking	gham	4b. City, Town,	or Location of Dea	2. Date of Death Month August 2	Day Year	3. Time of Death  11:20 a M
3	Funeral Director		8 Hersh Avenue  5. Social Security Number 213-09-8162  6. Security Number	7. Age	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days		s. 8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	ט	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carro	11	10c. City, Town or Lo		Westmins	Nov 27, ter	1910 Mar	yland 10d. Inside City Limits 1'XYes 2□No
	ath with the 23e or 28 unt be not	rai Direc	10e. Street and Number 8 Hersh Avenue			10f. Zip Code	21157		g. Citizen of What Co USA	ountry?
9036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Madical Exercities in the Distilled at	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ► N If Yes, Give Year or Dates:	10	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- no Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Madical Examiner is unit be notified at once.	Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a co <i>mpleted)</i> College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire ner/Oper	during most of wi	orking 1	6b. Kind of Business Upholste	
Maryland 2	ould be filed Mental Hyg tarked othe	To Be C	17. Father's Name (First, Middle, Last)  Irving H. Bucki				Jesse	<sup>ame (First, Middle, M</sup> Schaefer		
e, Mar	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (Ty, Hope M Rosenberger  20a. Method of Disposition		1101	Deer Pa	rk Road,	Rural Route Number, Westminst  Date 2		157
Baltimore,	Tilt. Pages partment of cortant: If it injury or o		1  Burial 2  Cremation 3		Krider's		08/3	0/2006	Vestminste	r, MD
Ä	Deg in so	-	23a. Part I. Enter the disease, or complishook, or heart failure. List only or	cations that caused	the death. Do not ent	-	s Street	, Westmins	ster, MD 2	
8760,	Physician and but side pe executed but side physician and supply side partial fransit supply side physician and supply sid	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  If any Isacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as an or or or or or or or or or or or or or	a consequence of):  a consequence of):  a consequence of):	)				Onset and Death
P.O. Box 6	Physician: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions cor	itributing to death bu	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	n: The law r ficate has be n. page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy perform 1 \( \text{Yes} \) 2	prior to death?	utopsy findings available completion of cause of 2 \( \square\$ No
ō	ng ffei ffei	ToB	examiner?	ospital: 1  Inpatie  28a. Date of Injur (Month, Day	y 28b. Time of	28c. Inju	ner: 4 🗌 Nursing	Home 5 Residen 28d. Describe hov		city)
Division	vitel or Attendi urs after death. ral Director: A	Certification:	3 Suicide 6 Could not be determined	building, etc				City or Town,		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  2 Medical Examin  29b. Signature and title of certifier	sician: To the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the tivestigation, in my o	opinion, death occ	urred at the time, dat	e and place, and due	to the cause(s)
)	NJL	_	freda	M.D.	and the one of	D00			8/28/	
**	Sta Registr		30. Name and address of person who co	32. Registra	eath (Item 23a) (Type, CACATANA) It's Signature	700/	Poole	E RD W	STOWSTER	2006 MO21157

			1 - For State Registrar	State of Mar		partment ertificate			nd M		jiene	006	2870
	Physici	an	Decedent's Name (First, Middle, Las	()						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	Paul H. Burrie  4a. Facility Name (If not institution, give		·-	4h Cihy 3	Tour or l	Location of	Dooth	August	20,		6:35∯
	Examin	er	Frederick Memo		nital		eder		Death			ederi	ck
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda		1 Year	If Under 2	4 Hrs.	8. Date of Birth Month, Day Dec . 24			ace (State or Foreign
	Director		220-20-0057	<b>X</b> M 2□ F	80 Yrs.	MOILITS	Days	Hours	MID.	Dec.24	,1925	Mary	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10	d. Inside City Limits
	Many 11 eh	tor	MD Carrol	1	Keymar								1 □Yes 2 📉No
	n the or 28e	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citizen of	What Count	ry?
	within 72 hours after death with the Maryland ene. Than "naturel", or Iteme 23a or 28a-f ehow na Medical Examinar must be notilliad at	ralD	8505 Forest and S	tream Club	Rd.	21	757				U.S.A	١.	
	er dez Iteme	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		3. Was Decede If Yes, spec	ent of His ify Cuban	panic Origi , Mexican,	in? (Spe Puerto l	cify Yes or No- Rican, etc.)		ce - America ck, White, e	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1		1 ☐ Yes 2	! <b>X</b> No	Specify:			Specif	y: Whi	te
ဝို	2 hou	ted	15. Decedent's Ed	ucation	16a. Dec	edent's Usua	Occupat	tion			16b. Kind of B		
2	thin 7 e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	) life	ve kind of work . DO NOT us	k done du e retired)	iring most o	of workir	og			_
2	filed wi Hygien other th	Cou	6		Fa	armer					Dairy		f
and	d be fi	Be	17. Father's Name (First, Middle, Last) Clarence C. Burri	er Sr.				18. Mother: Edna		(First, Middle, i	Maiden Sumar	ne)	
Maryland 21215-0036	should nd Me mark mark	To.	19a. Informant's Name/Relationship (7		19b. Ma	iling Address	(Street ar			Route Number	, City or Town	. State, Zip (	Code)
	alth a alth a 27 io		Helen A. Burrier	- wife						lub Rd.	-		
altimore,	es 1 a of He fitem r othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Domoual from State	20b. Place of Dis						20c. Location		
Ĕ	Pages ment of I		4 Donation 5 Other (Specify		Mt. Tal			1	3/23	/2006	Rocky	Ridge	, MD
Ball	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Hygiene. Depertment of the returnation of the Macilian and Mental Hygiene. Depertment of the Macilian and Depertment of the Macilian and Depertment.		21. Signature of Funeral Service Licen	e Varia		22. Name and			110	artzler			е
	40204		23a. Part1. Enter the disease, or comp	1070W						odsboro			Approximate
	Diam'r i ar		shock, or heart failure. List only of immediate Cause (Final	ne cause on each line	1 0	1 1 0	or dyllig,	, such as Co	ardiac o	respiratory air	631,	1	Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a. IVI2+ast	consequence of):	tope le	incur	-					
	Examiner		One and the line and distance	b	30,700 400,700 017.								
	ם יו	ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying		echeaquer es of).						_		
	and and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Pue to for as a	consequence of):								
760,	ate be executed hysicien and the burial-transit	calE			consequence ory.								
	ificate g physias the			d									
ŏ	death certific attending p	M/U	230. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		B⊟Ectopic pre					23d. Da	te of deliver	y
.O. Box	e deat he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir		Other (spe					Mo	onth D	Day Year
<u>Р</u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Phy	9 Unknown  Part II. Other significant conditions co		ant requision in the			in Dead		22a Did tal			
ds,	signe d be c	þ	Partil. Other algumeant conditions of	TRIBUTING TO GEAR DUT	not resulting in the	underlying ca	iuse giver	ım Panı.		1 \( \text{Y}\)	/		cause of death?
Ö	w require been si should t	ete								24a. Was a			sy findings available
Re	The lav te has age 2	Completed								autops	iy ned≱?	prior to com death?	pletion of cause of
Ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place o	of Death	1 ☐ Yes 2		1 ☐ Yes 2	I No
<u>&gt;</u>	hysic his ce	To	examiner? 1  Yes 2 No	Hospital: 1 Inpatient				4 🗀 140/5	sing Hor	ne 5□Reside	ence 6 □Oth	ner (Specify)	
Ĕ	ding P h. After t funera	inol.	27. Manufer of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		3c. Injury a Work?			8d. Describe ho	ow injury occur	red	
Division of Vital Records,	death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	v - At home farm	M street factory		es 2 □No		8f. Location (St	reet and Numb	er or Rural	Route Number
<u>S</u>	efter i Dire d in b	Certification:	4 Homicide determined	building, etc.	(Specify)	otroot, ractory,	omoo			City or Town	n, State)	or or ridiar	noute rumber,
	To the Hospital or Attending Physician: The within 24 hours effor death, within 24 hours effor death, completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of iner: On the basis of e	my knowledge, de	ath occurred a	it the time	, date and	place, a	nd due to the ca	ause(s) and ma	anner as sta	ted.
	the H nin 24 the F pplete	Medical	one)	and manner state	ed.				occurre				
	Con Con	~	29b. Signafure and title of certifier			29c.	License			2	9d. Date signe	P	ay, Year)
	MIL		and the second s	ampleted as	ath (learn 00 - 1 CT	- D::-"	D6	4394			0/22	106	
	6		30. Name and address of person who o	ompleted cause of dea	400 W . 7		Fr	ederi	ck	MD 2170	11		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature			Cuerr	un,	110 21/0	, ,		
	Registr	ar	AUG 2.5 7	nna Elec	w #	donle	,						

			For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and I Death		giene 2006	28709
	Physici /Medic	ai	1. Decedent's Name (First, Middle, Last)	SNIL	DER	BABY	LON Location of Death	2. Date of Dea	Day Year	3. Time of Death
1000	Examin	er	4a. Facility Name (If not institution, give st Carroll Hospital C			Westm	inster	1	Carro	
10.	Funeral Director		5. Social Security Number 6. Sex 220 -30 -6660 1	_	yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year Cou	place (State or Foreign intry) yland
	Maryland I-f show	tor	10a. State 10b. County  Maryland Carrol		c. City, Town or Lo	cation	Westmin	ster		10d. Inside City Limits 1 Yes 2 □ No
	with the	Director	10e. Street and Number 131 Willis Street	1		10f. Zip Code	21157	1	Og. Citizen of What Cou	intry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Exam and interesting a confiled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Yes, 2 \( \) No If Yes, Give Year or Dates: WW		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	within 72 hou ene. then *nature he Medical E	Completed	15. Decedent's Edución (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decec	dent's Usual Occup kind of work done DO NOT use retired Self Emp	during most of wor d)	king	16b. Kind of Business/le Bookkeepin	,
and 2	d be filed ental Hygie ced other c svent, tt	To Be Co	17. Father's Name (First, Middle, Last) D. Snider Babylon	-4			18. Mother's Nan	ne (First, Middle, a	Maiden Surname)	
Mary	S D E	Ţ	19a. Informant's Name/Relationship (Type G. Evelyn Babylon,		1	•			r, City or Town, State, Zi	p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health is Important: if Item 27 is any injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Ob. Place of Dispo cem <i>etery</i> , crem	natory or other plac	atory 3	Date 3/28 2006	20c. Location - City or T Winfield,	
Balti	permit. Departm tmporta any inju		21. Signature of Funeral Service Licensee		191 22	. Name and Addre	ss of Facility My	ers-Durb	oraw Funera ster, MD 21	
	Physician		23a. Part Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	death. Do not ente		g, such as cardiac	a i	est,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed with the second of the second	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a co	nsequence of):  VAC at a resequence of):	rbythu				
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliving Month	rery Day Year
α.	luires that the signed by ald be detacted	by	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the un	nderlying qause giv	en in Part I.		pacco use contribute to	the cause of death?
Records,	The law requir te has been si bage 2 should	Completed	Hyperli	ridemi'a	<u> </u>	.,		24a. Was a autops perform	brior to co	opsy findings available ompletion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	spital:		· all Don Oth	oc	th (Check only on	(8)	
Division of	문 등 등	itlon: To	1 Yes 2 No 27 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yes	28b. Time of Injury	28c. Injur	4   Nursing n		ow injury occurred	( <b>fy</b> )
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stropecify)	eet, factory, office		28f. Location (Si City or Town	reet and Number or Rur n, State)	al Route Number,
	ne Hospita 24 hours ne Funera bletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physical (Check only one)	cian: To the best of my er: On the basis of exa and manner stated.	y knowledge, death mination and/or in	occurred at the tir	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
		M	29b. Signature and title of certifier	rle.		29c. Licens			9d. Date signed (Month,	
,	WITHA		30. No ge are address of person who con Janus L. Forsh.		(Item 23a) (Type,	Print)	w #114	Flder	8-23-200 sburg, net	21784
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 5 70	32. Registrar's S	Signature	GICH VO.	1 1110	-,44	),	. ~

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Betty Marshall Bixler AUGUST 21, 2006 6:50 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT 8, 1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Yrs 218-24-1752 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturat", or items 23s or 28s-f show the Medical Examiner must be notified at Westminster Carroll Maryland 1 ¥Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 30 Locust Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or flems 23a any injury or other traumatic event, the Madical Examiner miner other. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Dietary Assistant 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Ellen Finn John A. Marshall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Locust Street, Westminster, MD 21157 John V. Bixler, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 08/23 20c. Location - City or Town, State 1 ☐ Burial 2 图 Cremation 3 ☐ Removal from State Winfield, MD South Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediale Cause (Final Physician CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical After this certificate has been signed by the attending integral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Unknown CARDIAC BYPASS SURGERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 (2) Yes 2 (2) No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 1106 WJL D 28244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOWZIA TAQI OSLER DRIVE TOWSON, MARYLAND 21204 M. D., 76/01 31. Date filed (Month, Day, Year) State AUG 25 2006 Registrar

		-	1 - State State Registrar	of Maryland		artment of Hertificate of L			giene 2006	28711
	Dhusisi		Decedent's Name (First, Middle, Last)	DDIDDE	т т			2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		BENJAMIN THOMAS	BRIDDE			1	Aug	28 2006	2:59 PM
7	Examin	ĕr	4a. Facility Name (If not institution, give street and Genesis HealthCare		ines	4b. City, Town, or Eas			4c. County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		irthplace (State or Foreign Country)
	Director		220-28-1044	73	Yrs.	Months Days	riours iviat.	5/19/	1933 Ma	aryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo			<del></del>		10d. Inside City Limits
	a-fsh	ctor	MD Talbot			]	Easton			1 🖾 Yes 2 🗆 No
	after death with the Maryland or Items 23s or 28a-f show nither a wat be notified at	Funeral Director	10e. Street and Number 610 Dutchmans Lan	е		10f. Zip Code	21601		10g. Citizen of What C United Si	
		ner	Armed	ecedent Ever in U. Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36		by Fi	If Yes,	s 2 🖾 No Give r Dates:		1□Yes 2 <sup>X</sup> No	Specify:		Specify:	Black
2-0	72 hours "natural",		15. Decedent's Education (Specify only highest grade complete	d)	16a. Dece	dent's Usual Occupa kind of work done d	ition Jurina most of work	ina	16b. Kind of Busines	s/Industry
121		Completed	Elementary/Secondary (0-12) College	9 (1-4or 5+)	life.	DO NOT use retired) Unknown	, , , , , , , , , , , , , , , , , , , ,		Unknow	n
d 2	Hygi other ent, I	Be Co	1 2 17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
/lan	2 should be and Mental Is marked of aumatic eve	To B	Unknown Robbins				Rache	1 Bri	dde11	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Lisa Jackson/Daught	or		ng Address <i>(Str</i> eet a L West 7			r, City or Town, State, Chester,	- 10010
	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - City of	
ō	Pages lent of nt; If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☑ Donation 5 ☐ Other (Specify)			Gift Re		/2006	Hanover,	Maryland
Baltimore,	permit. Pages Department of Important; If i any injury or once.		21. Signature of Funeral Service Licensee	Coale	1	2. Name and Addres		1 Home	,Federal	sburg, MD
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death n each line.	n. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	andios	ugepi	ethy				years
	/Medical Examiner		Due	to (or as a consequ	u <b>6</b> fice of):	1				inean
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (as a consequ	uence of):	4	11.			Jan
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequ	lerssi-	( , general	1320			gears
8760,	cate be execu physician and the burial-trar	al E	Due Due	to (or as a consequ	dence on.				4	
9		ledical	d			_				
Вох	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	in the past 12 months?	outcome of pregna e birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of d	elivery Day Year
	that the dea led by the at detached fo	ysici	1 Voc 3 DNo	egnant at time of de known	eath 5	Other (specify)				24,
, P.O	s that t ned by a detac	by Ph	Part II. Dther significant conditions contributing to	death but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records,	w requires been sign should be	led b	Villagers-dependent	ud-stag	e rong	el faiture		1 🗆 Y	'es 2 □ No 3 □ l	Probably 4 Unknown
ecc	has be	Completed						24a. Was autop perfor	sy prior to	autopsy findings available completion of cause of
al F			OF IN-				00 Pl / P	1 Tes	2 No 1 □ Ye	
	ysicia is certi directo	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \text{No} \) Hospital: 1	□Inpatient 2□	ER/Outpatier	nt 3 DOA Othe	26. Place of Deat Pr. 4. Nursing Ho		ence 6 □Other (Sp	pecify)
Division of	ding Ph h. After thi funeral	on: T	27. Manner of Death 28a. Da Natural 5 ☐ Pending (N	te of Injury Ionth, Day Year)	28b. Time o Injury	Work		28d. Describe h	ow injury occurred	
Sio	ttendi death. stor: A	Certification:	2 Accident investigation	ace of Injury - At ho	me farm st		/es 2 □No	28f Location (5	itreet and Number or	Rural Route Number.
Div	after of Direct of in by	ertif	4 Homicide determined	ace of Injury - At ho ilding, etc. (Specify	/)	reet, factory, office		City or Tow		Toral Flosio Francos,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director.	Medicai C	29a. Certifier (Check only one)  Certifying Physician: To the control of the cont							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	2, .		29c. License	number		29d. Date signed (Mo	nth. Day, Year)
			11/13	1 MD			025933	3	8.29.	06
			30. Name and address of person who completed of MICHAEL CROWLEY	ause of death (Item	23a) (Type,	DUTCH W	IAN'S L	ANE	EASTON	MD 21601
	Sta Regista		31. Date filed (Month, Day, Year) 33	Registrar's Signa	ture	out)				

Benjamin Briddell

		1 = For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment o tificate	of Heal of Dea	ith and Nath	fental Hygi	ene 2	006	28712
Observation)		1. Decedent's Name (First, Middle,	Last)						2. Date of Death Month	Day	Yeer	3. Time of Death
Physicia /Medic		Ernest Bailey							Aug	14	2006	9:10 A M
Examin	er	4a. Facility Name (If not institution,		ımber)				ation of Death			nty of Deeth	
		706 Smith St.,  5. Social Security Number	Apt. 4	7. Age (In yrs.	last birthday)	Sall If Under 1 Y		inder 24 Hrs.	8. Date of Birth	W1	COMICO 9. Birthp	lace (State or Foreign try)
Funeral Director		222-22-6406	1☐M 2□ F	69	Yrs.	Months D	ays Ho	ours Min.	8. Date of Birth (Month, Day, Apr 15,1	937	Coun VA	try)
P.		Usual Residence of Decedent		40- 0	- T							Od. Inside City Limits
show	-	MD Wicon	ni co		ity, Town or Lo lisbury						'	1X Yes 2 No
with the Marylar a or 28a-f show be recilled at	Director			, Sa	TISDUL	10f. Zip Co	ode		10	n Citizen d	of What Coun	
with t		10e. Street and Number 706 Smith St., A	nt 1			2180				-	USA	,.
72 hours after death with the Maryland natural; or Itams 23s or 28s-f show dical Examiner must be recitified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.			ic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. R	ace - Americ	
after of		1 Never Married 2 Marri	Armed F ed 1 ☐ Yes	2 XNo		itYes,specify 1∐ Yes 2∑s		exican, Puerco <i>ecify:</i>	Hican, etc.)		lack, White, cify: Blac	
ours a	d by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:		1 1 1 e 2 5 tř	g NO SP	ocny.		Sper	ony. Diac	K
	Completed	15. Decedent (Specify only highes	s Education t grade completed	)	(Give	dent's Usual C kind of work o DO NOT use i	done during	g most of work	ding 1	6b. Kind of	Business/Inc	lustry
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Hygie ther ant,	မ င်	6th 17. Father's Name (First, Middle, I	ast)		1			Mother's Nam	e (First, Middle, M	aiden Sum		
ic ev	m	William Bailey					Ja	anie Ba	iley			
should ind Men in marke umatic	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailii	ng Address (S	treet and A	Number or Rui	ral Route Number,	City or Tox	vn, State, Zip	Code)
is 1 and 2 should be filed within the all and 2 should be filed within the all and a should be filed within the all and 27 is marked other than other traumatic event, the M		Zina Delancey/ca	se worke									ry,MD 21801
of He		20a. Method of Disposition 1 ☐ Burial 2 XCremation	3 □Removal from		Place of Dispo cemetery, crei	sition (Name natory or othe	of er place)		Date 2	0c. Locatio	n - City or To	wn, State
permit. Pages 1 Department of H Important: If ite ony injury or ot	Ŋ	* 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Cre					/2006	Delma	r, DE	
permit. Depart Import eny inj		21. Signature of Funeral Service	ensee			2. Name and A Ewis Ñ			neral Hom	ie.		
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		shock, or heart failure. List	only one cause on	each line.	un. Do not sin	or the mode c	a dying, so	orr as cardiao	or rospiratory arro	ot,		Interval Between Onset and Death
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Examiner			Due to	o (or as a conse TN	quence or):							
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attence for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al déath 3	Ectopic preg					Date of delive Month	Day Year
the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		33401	_ 0 ii 10 i (0p00	")/					
res that the de signed by the a be detached i		Part II. Dther significant condition	ns contributing to	death but not re	sulting in the u	nderlying cau	se given in	Part I.	23e. Did tob	acco use c	ontribute to th	ne cause of death?
n sign	ed by	HYPERCHOLEST	EROLEMI	Α,					1 □ Ye	s 2 🗆 No	3 Prob	ably 4 Unknown
aw requires been size should I	Completed								24a. Was an	24	b. Were auto	psy findings available mpletion of cause of
The la	E								perform	ed? No	death?	
ian: srtifica ctor, p	Be C	25. Was case referred to medical examiner?					26.	Place of Dea	th (Check only one			
ding Physician: The lav h. After this certificate has funeral director, page 2:	To	1 Yes 2 No			☐ ER/Outpatie			☐ Nursing H	ome Reside			r)
ing Ph	on:	27. Manner of Death  □ Natural 5 □ Pendin	9	e of Injury onth, Day Year)	28b. Time of Injury		Work?	a CIN-	28d. Describe ho	w injury occ	curred	
ttend death stor: /	Certification;	2 Accident investig	not be 390 Pla	ce of Injury - At I	home farm et	M factory of	1 Tes	2 🗆 NO	28f. Location (Str	eet and Nu	mber or Rura	Il Route Number
or A after Direc	ertif	4 Homicide determ	ined 200. Fla	ding, etc. (Spec	eify)	ieer, ractory, c	niice		City or Town	State)	mbor or riare	7110010110111001,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical Co	(Check only 2 Medical	Exeminer: On the	basis of examin					, and due to the ca rred at the time, da			
the I thin 2. the I mplet	Med	one)  29b. Signature and title of certifie		inner stated.		29c. I	_icense nur	mber	29	d. Date sig	ned (Month,	Day, Year)
A T W C		1 MAN	L.	H D			006			8/22	106	
		30. Name and widness of person	who completed ca	use of death (Ite	em 23a) (Type	Print)				7	1	
		YOGESH VOHR		ENSTERI	V SHOP	E OR	SUI	TEB	SALISBU	RY +	10, 21	804.
Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	-	_	1					٠
Regist	rar	ALIC 2	3 2006	No.	K	Coads 1						

ORIGINAL

			for State Registrar	State of N	•	partment of F ertificate of			giene Reg. No.		
			Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medi		Joyce Elaine Buh	lman				August	26,		10:15 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	street and number	)	4b. City, Town, o	r Location of Death		4c. Co	ounty of Deeth	
			10522 William Tel	1 Lane		Colu	mbia			Howard	
	Funeral		Social Security Number     6. Security Number		ge (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 3/1/19	h v, Year)	9. Birthpi	lace (State or Foreign try) York
	Director		0/5 30 21/2	□M 2X1F	68 Yrs			3/1/19	938	New	York
	pu ≱		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10	0d. Inside City Limits
	anyla shov	_									1 ☐ Yes 2½ No
	88 - R	ctc	MD Howard		Colum				10 000		
	or 2	by Funeral Director	10e. Street and Number			10f. Zip Code	4.4		•	n of What Coun	try?
	ath v	B	10522 William Te			2104			USA		an Indian
	tems	une	11. Marital Status	12. Was Deceden Armed Forces		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14.	. Race - America Black, White, e	
36	s afte	ΥF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2X If Yes, Give		1 ☐ Yes 2010 No	Specify:		Sp	pecify: Whi	ite
8	hour turel	pg p	15. Decedent's Ed	Year or Dates		cedent's Usual Occup	nation		16h Kind	of Business/Ind	dustav
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ha Medical Examinat hust be notified at	Completed	(Specify only highest grad	de completed)	(G	ive kind of work done e. DO NOT use retired	during most of work d)	ring	100. 14110	0, 040, 103, 1110	John
12	withi ene. than	Щ	Elementary/Secondary (0-12)	College (1-4o	(5+)	fice Manac			Engi	ineering	ı
9	filed Hygid Sther		17. Father's Name (First, Middle, Last)		1 0-		18. Mother's Nam	e (First, Middle,			<del>/</del>
Maryland	should be filed within and Mental Hygiene. marked other than imatic event, the Market than the	To Be	Charles Frances	Zoll			Gertru	de Marie	e Clar	cke	
7	2 should land Menis marke	F	19a. Informant's Name/Relationship (7		19b. M	ailing Address (Street	and Number or Rur	al Route Numbe	er, City or T	own, State, Zip	Code) 21104
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, in a Medical Examinar must be notified at	ĺ				220 Marrio				tsville	
á	1 ar Hea Hem		David Buhlman/sc 20a. Method of Disposition	211	20b. Place of Di	sposition (Name of		Date 1-12		tion - City or To	
lo	Pages nent of int; if its		1 ∏Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from Stat	9	rematory or other pla	1	12000	011	seemed 1 from	1400
Baltimore,			21. Signature of Funeral Service Licen.			Mem. Par	ss of Facility Hall	72006 rrv H. V	Vitzke	s Fami	MD Lly Fii Inc.
Ba	permit. Departi		1/10.101	1.	M01442		Columbia				MD 21043
	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	ed the death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory as	rest,		Approximate
	<b>⊕</b>		shock, or heart failure. List only of Immediate Cause (Final	one cause on each	line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.	s a consequence of):	nc w	rain c	ance	\		WOUNTE
98- 7-	Examiner			Due to (or a	s a consequence or):						
		P.	Sequentially list conditions,	b. Due to (or a	s a consequence of):						
	uted Insit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	execu n and al-tra	Exa	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
29/	ificate be executed g physician and as the burial-transit	edicai Examiner		d							
68760,	± 00 €	edic									
Вох		<u>~</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					230	d. Date of delive	ry
m	death a atte	cia	in the past 12 months? 1 ☐ Yes 2 No	4 Pregnant	2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify) □	y 			Month	Day Year
0	the oy the ache	hys	9 □ Unknown	9□ Unknown							
σ,	ires that the death cer signed by the attendin d be detached for use	Completed by Physician/M	Part II. Other significant conditions co	ontributing to death	but not resulting in th	e underlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to th	e cause of death?
ğ	quire n sig uld bu	D D	Nune					1 🗆 ነ	/es 2□1	No 3□Proba	ably 4 Unknown
00	w requir s been si should	jete						24a. Was		24b. Were autop	osy findings available
Re	he la e has ige 2	ПE							med?	prior to con death?	npletion of cause of
<u>a</u>			25. Was case referred to medical				26. Place of Deat	1 Yes	215 No	1 🗆 Yes	20,46
Division of Vital Records,	Physicien: The lav this certificate has ral director, page 2	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outpa	tient 3 DOA Oth	200			Other (Specify	()
o	± ± ±	1	27. Manner of Death	28a. Date of In	jury 28b. Tim	e of 28c. Injur		28d. Describe I			/
Ö	Attending Ph r death. ector: After th by the funeral	i i	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, E	Pa <i>y Year)</i> Inju		Yes 2 No				
<u> S</u>	Attendi	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of I	njury - At home, farm	street, factory, office		28f. Location (5	Street and N	Number or Aurai	l Route Number,
Ö	afte afte	Certification;	4  Homicide determined	building,	etc. (Specify)			City or Tov	vn, State)		
	Hospital 14 hours a Funerel I tely filled					eath occurred at the til					
	To the Hospital or Attend within 24 hours after death To the Funerel Directors: completely filled in by the t	edicai	(Check only 2 Medicel Exemone)	iner: On the basis and manner		r investigation, in my o	opinion, death occur	red at the time,	date and pla	ace, and due to	the cause(s)
	To the within 2 To the complet	M	29b. Signalure and title of certifier	0		29c. Licens	se number		29d. Date s	signed (Month, L	Day Year)
	. ,, ,		> Welus &	CWYYM	( DWY	00	16588	3	É	3/28	10Co
(1)	0		30. Name and address of person who o	completed cause of	peath (Item 23a) (Ty	per Print)	Margaril	0110	2 (	ut	1
9			9501 Old ANNAPO	Is floa	a sinco	4 (12h	MADIM (	conex	CIV	Y	
	St	ate	31. Date filed (Month, Day, Year)	32. <b>Seg</b> is	strar's Signature	1					
hr.	Regist	rar	AUG 2 8 2	UUD /	we st.	good					
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per Dr. C859 09/11/06dhb

For AMEND#1 per phy. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Death

Reg. No. 2006 1- For AMEND#1 per phy. State of Maryla State Registrar 8/23/06 AACO HEALIH DEPT. CMH 1. Decedent's Name (First, Middle, Last Arthur, Brunstron 2. Date of Death Day Year Month Physician am 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1169 Claire Road Crownsville Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 26 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1000M 2□ F Yrs Director 029-28-3406 68 1938 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, the Mccical Examiner must be notified at 1 ☐ Yes 2 ₩ No **Funeral Director** MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1169 Claire Road 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Completed by If Yes, Give Year or Dates: 1961-64 Specify Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NSA Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Arthur Brunstrom ပ္ Mildred Frances Quist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhodena D. Brunstrom (Wife) 1169 Claire Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 8-24-2006 Millersville, MD Baldwin Mem. Cem. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 9 851 Annapolis Road, Gambrills, MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Nonsmall cell una disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner o the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sign, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No : After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059173 of death (Item 23a) (Type, Print) Kathleen Kemmer 6 77 maples 31. Date filed (Month, Day, Year) State Registrar

	·		1 - For State Registrar	State of Mary	land / Depa <i>Cer</i>	irtment of H	Death	Reg	g. No.	
	Physicia /Medic		1. Decedent's Name (First, Middle, La: Grace Agath	G1	onas			2. Date of Death Month August	Day Year 22, 2006	3. Time of Death  1:15 P M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	
			Fairland Nursin	<u> </u>		Silv If Under 1 Year	ver Sprin			tgomery
ì	Funeral Director		578-52-0396	OX 7. Age (in 81	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 29	Year) Co , 1924 Was	hplace (State or Foreign untry) hington, DC
	tand ow		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Many	ţċ	Maryland	Howard	E	llicott (	City			1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23a c	ral	5021 Brampton Pa	rkway		2014			USA	
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydione. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Marical Exama are must be notified at one.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 <b>XX</b> io	ispanic Origin? (Sp. un, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
5	2 hou	ted	15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	ation	ing 1	6b. Kind of Business/	
7	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work f)	ing		
V	ed wil	Con	12		La	b Technic				Government
2	tal High off	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, Mi	aiden Sumame)	
2	1 Men narke	L L	Nicholas Nicast		10h Mailia	a Address (Street		y Longo	City or Town, State, 2	Fin Code)
2	d 2 sh th and 7 Is n treun		19a. Informant's Name/Relationship (	2).	1	•			•	
บ้	1 an Heali tem 2		Michael G. Chaco 20a. Method of Disposition		0b. Place of Dispo- cemetery, cren	_Brampton sition (Name of	<u>Parkway</u>		tt City, M. Oc. Location - City or	
5	age = age		1 Surial 2 Cremation 3 4 Donation 5 Other (Specif	THemoval from State  _	cemetery, cren Fort Linc		Aug	ust 25	<b>D</b>	
allillo	artme orter injur	1	21. Signature of Funeral Service Licer	,,					Home Inc	twood, Marylan
ŭ	Ded grad		10000 SC	Infa,						g, MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumonia						Onset and Death  1 Week
	/Medical		resulting in death)	Due to (or as a cor	nsequence of):					
	Examiner		Sequentially list conditions,	b						
-	sit 8d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence of):					
	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					
00/00	ficate be executed physician and is the burial-transit	alE		d					- 4	
00	Ch m	edical		_ 0						
C. DOX	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1072.V		23d. Date of del Month	ivery Day Year
ŗ	fhat hed by deta		Part II. Other significant conditions of	contributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords	n sign	d by	Respiratory Failu	re				1 ☐ Yes	s 2□No 3□Pr	obably 4 DUnknown
15	25 8	ompleted						24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of
Ö	an: T tificat tor. pa	O	25. Was case referred to medical				26. Place of Deat	h (Check only one	131	2□ No
>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☐Mo	Hospital: 1   Inpatient	2 ER/Outpatien	t 3 DOA Oth	er	27/	nce 6 □Other (Spe	cify)
ō	ng Ph Iter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	w injury occurred	
SION	sndii eath. or: A the fu	catle	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No			
18 18	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of fnjury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
1	pital ours a eral [ filled		29a. Certifier	nysician: To the best of my	v knowledne, death	occurred at the tin	ne, date and place	and due to the car	use(s) and manner as	stated
	# Hos 24 hc Fun etely	edical		miner: On the basis of exa and manner stated.						
	ro th Fo th	Me	29b. Signature and little of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	n		1 BN4			D28	3656		August 24	, 2006
	1		30 Name and address of person who Ravi Passi, M.D.	completed cause of death 8609 Second	(Item 23a) (Type, Avenue,	Print) #404B,	Silver Sp	ring,MD	20910	
	Sta		31. Date filed (Month, Day, Year) AUG 2 5 2	32 Registrar's S	Signature Signature	ali)		-		
	Registr	ar	AUG ~ U L	131 Bur	n. Jahra	Mana.				

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EMERSON Lee CRUMBACKER 8:14 AMM 24 Aug 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Frederick 13221 Catoctin Furnace Rd. Thurmont 8. Date of Birth (Month, Day, Year)
Jan 28, 1949 Maryland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months Days Hours Yrs. 57 Director 215-48-8662 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County rel', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Frederick Thurmont MD Direct 10f. Zip Code 10g. Citizen of What Country? 13221 Catoctin Furnace Rd. 21788 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed other then "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bob's Welding 12th Welder/Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Woodrow Francis Crumbacker Carrie Mae Scheller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13221 Catoctin Furnace Rd. Thurmont, MD 1788 permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau Krystal Gilbert - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/2006 Dennings, MD Sams Creek Cem. 21. Signature of Funeral Service 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death on the cause on each line.

| Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Application | Ap Immediate Cause (Final disease or condition resulting in death) 140CARDIA **Physician** MOUNS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 No Division of Vital within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 12Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the test of my knowledge death occurred at the fine data and place and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO21702 A.Z. HEGAG Johson Dru nomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

		•	1 - For State Registrar	State of N	Marylan		artmen rtificat			and M		giene Reg. No	2006	28717
			Decedent's Name (First, Middle, Last,	)							2. Date of Dea Month			3. Time of Death
	Physici /Medic		SADIE RUBIN D	REISEN			,				08/22/2	2006		4:32 A M
	Examin	er	4a. Fecility Name (If not institution, give				·		Location of			40.	County of Death	
	Funeral		15101 INTERLACHEN  5. Social Security Number 6. Sec			last birthday)		LVER	SPRI If Under 2		8. Date of Birtl	h		TGOMERY lace (State or Foreign
	Director			]M 2 <b>X</b> )F	91	Yrs.	Months	Days	Hours	Min.	8. Date of Birth April Dan	$SO^{ear}$	1915 Cour	ntry) DC
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Manyli f eho	ō	MD Montgom	ery		lver S		5						1 XYes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip					10g. Cit	izen of What Cour	
	23a o		15101 Interlachen	Drive #7	′26 				20906	)			Unit	ed States
	be filed within 72 hours after death with the Maryland nat Hyglene.  do other than "natural", or Iteme 23a or 28a-f ehow event, the Medical Examinar much be modified at	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?		Was Dece II Yes, spe	dent of His	spanic Orig n, Mexican,	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		<ol> <li>Race - Americ Black, White,</li> </ol>	
36	Irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2) If Yes, Give Year or Date:	_		1 🗆 Yes	<b>¾</b> □ No	Specify:				Specify: Wh	ite
2-0	72 hou	ted	15. Decedent's Edu (Specify only highest grad			16a. Dece			ition Juring most	t of workin	)a	16b. K	ind of Business/In-	dustry
21	Athin han "	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT u				.9	^	7.7	
, D	e filed within al Hygiene. other then '		12 17. Father's Name (First, Middle, Last)			Homem	aker		18. Mothe	r's Name	(First, Middle,		Home Sumame)	
an	w - 0 =	To Be	Nathan Rubin								nknown'			
Maryland 21215-0036	2 should be and Mental le marked demarked aumatic ev		19a. Informant's Name/Relationship (Ty				-						or Town, State, Zip	Code)
≥,	and 2 ealth m 27 I		Paddy Abrams - Dau	ghter	1001 5		de la companya della companya della companya de la companya della		ne Ro		.lle MD			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ie marked eny injury or giher traumatic ev		20a. Method of Disposition 1 XBurial 2 Cremation 3 XIF		te Kin	Place of Dispo emetery, crev g Davi	naton (Na) naton or o .d Men	me or other place NOT 18	1 8	3/25/	06		ocation - City or To .11s Chur	
Ë	artme ortani injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		- 1	22	2. Name ar	nd Addres	s of Facility	Υ.,	1.0		1 51	
ä	Depa Depa Impo eny ii		100			10	91 R	nckvi	11e F	Edwar Pike	d Sage. Rockvi	L Fu 11e	neral Di MD 20852	rection Inc
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caus	sed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Cong	estive	Caro	liomy	opath	ny				1 Year
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):								
		er	Sequentially list conditions, if any, leading to infinediate	Due to (or:	as a nunsay	uence of):			-					
	cuted nd ransit	Examiner	il any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	s										
30,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or a	as a conseq	uence of):								
68760,	death certificate be executed e attending physicien and od for use as the burial-transi	dicai		d						·	<del></del>			
Box 6	ath certific attending pl for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom									23d. Date of delive	ery
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COL	> 0 20	lete									24a. Was	an –	24b. Were auto	psy lindings available
Division of Vital Record	The law sete hes b page 2 sl	ompieted									autop perfor		prior to co	mpletion of cause of
ital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only o		103	2010
) (	hys his	ဥ	1 ☐ Yes 2 ₹ No			ER/Outpatier			4 [] Nui				6 Other (Specific	y)
no	ding f h. After funer	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I	Day Year)	28b. Time o Injury	м	28c. Injury Work	rat i? ∕es 2.∐N		8d. Describe h	iow inju	ry occurred	
/isi	il or Attending P after death. I Director: After t d in by the funera	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At ho	ome, farm, str							d Number or Rura	il Route Number,
ā	s afte	Certification:	4 Homicide determined	building,	etc. (Specify	y)					City or Tow	vn, State	) 	
	Hospital or Atti 24 hours after de Funeral Directo stely filled in by th	edicai	29a. Certifier 1X Certifying Phy (Check only one) 2 Medical Exami	sician: To the be ner: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a th occurre	nd due to the old at the time, o	cause(s date and	and manner as sid place, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	with manual			29	c. License	number			29d. Da	te signed (Month,	Dey, Year)
,	20		MIZU	n				D0051	20			Aug	ust 22,	2006
	~		30 Name and address of person who commichael Emmer 6316	mpleted cause of Democra	death (Item	n 23a) (Type, oulevar	Print)	theso	la MD	2081	7			
		10	31. Date liled (Month, Day, Year)		strar's Signa	iture;	P 10	1						
1	Sta Registr		AUG 25 2		ر معروب	1. A	melle	c'						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:56 P M Gerald Edward Druin, Sr. 23 2006 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton P.G. County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. | Months | Days | Hours | Min. | October 26, 1932 7. Age (In yrs. last birthday) 73 Yrs. 9. Birthplace (State or Foreign Country)
2 Virginia Social Security Number 228–34–0243 **Funeral** 10XM 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or itema 23a or 28a-f show the Madical Examiner must be notified at Maryland St. Mary's Calofornia 1 ☐ Yes 2 ▼ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23238 Rosewood Ct., Apt. 1045 20619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Ď 3 ☐ Widowed 4 ▼ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Supertendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked o Pages 1 and 2 should be Leroy Edward Druin Eleanor C. George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a importent: if item 27 ie any injury or other tres once. Sandra Hatcher/Sister 29714 Marshall Rd., Mechanicsville, MD 20659 20b. Place of Disposition (Name of August 25, Charlotte Hall, MD Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) tonle mysc.m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1-mm Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed androgen that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed to de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20824 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9450 Penn Ale #18 pex Max/bord Janasin 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 () () 6 I. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Friesland Μ. 8:45 A M August 25, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 431 E. Red Hill Road Conowingo 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, )
Sept. 8, 9. Birthplace (State or Foreign **Funeral** Year) 1926 Fairview, PA Days Hours 1 ☐ M 2 K F 194-20-9804 79 Sept. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov ust be notified at Maryland Ceci1 Conowingo 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 E. Red Hill Road 21918 or Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumetic event, It a Madical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Pellicone Elsie Strunk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Daniel Friesland 431 E. Red Hill Road Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 29, 2006 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holly Hill Cemetery Baltimore, MD ` 4 ☐ Donation 6 ☐ Other (Specify) ervice 22. Name and Address of Facility Crouch Funeral Home 127 S. Main St. North East, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) esopropi /Medical Due to (or as a consequence of) Examiner Me cico Esquentiary list conoctons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit seron resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical Spine IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1∐ Yes 2XXNo To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification; Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) To tha within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of per on the completed cause of death (Item 23a) (Type, Print) 223 wmom st. Elktoni 32 Registrar's Signature 31. Date filed Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 2006 1625 25 JOANN SYLVIA FEIFER /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESTER RIVER HOSPITAL CENTER CHESTERTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplece (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dev. Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 K F PENNSÝLVANIA 63 10/12/1942 Director 189-32-0009 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State ral', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No CHESTERTOWN MD KENT Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21620 115 CLIPPER WAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. e filed within 72 hours after day Hygiene. 1 Never Married 2 Marned 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: δ 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Modical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 4 TEACHER 12 should be filed w h and Mental Hygier 7 Is marked other th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permil. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked c any injury or other traumatic eve once. SOPHIE UNKNOWN STEPHEN GOLEMBIEWSKI ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2090 ST. JAMES RD., MARRIOTSVILLE, MD 21104 MICHELLE ZINN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ST. PETER'S CEMETERY 08/29/2006 QUEENSTOWN ,MD 5 Other (Specify) 21. Signature of Juneral Sovice Licerses P.A. P.A. HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ostructivo **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of) P.O. Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Q 1 les 2 No 3 Probably 4 Unknown Completed Oronary Artara 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe page 2 certificate has Hupartonsion 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DNo 2 ER/Outpatient 3 DOA Certification; To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 124 hours after death.

The Funerel Director: A pletely filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely t (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1190 Galana Marin Donahor 32. Registrar's Signature 31. Date filed (Month, Day, Year) 200€ 28 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28721 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 **Physician** AŬĜÜST 2006 MARGARET GRZESZKIEWICZ 12:15 PM LETETIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRIENDS NURSING HOME MONTGOMERY SANDY SPRING | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 17, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 282 F 218-16-2395 82 Vrs Director 1923 Washington, D.C. Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene. ant: if item 27 ie marked other then "neturel", or items 23a or 28a-f show ary or other treumatic event, the Medical Examination mantice actified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery **Brookeville** 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22001 Georgia Avenue 20833 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ð Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Merryman Carrie Hicks ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2727 Triadelphia Lake Rd., Brookeville, Md. 20833 Mark Grzeszkiewicz / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State important: if its eny injury or of once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 8/24/06 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. 20882 P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUO ec U 20 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine anding physiclen and use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death signed by the a'd be detached fr 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CCPD 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed FibR. Mat 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has b irector, page 2 sl Division of Vital 1 ☐ Yes 2 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending To the Hospital or Attending within 24 hours etter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai Zira. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 033426 august 23 2006 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward P. Taubman, M.D. 18109 Prince Philip Dr., #275, Olney, Md. 31. Date filed (Month, Day, Year) AUG 25 egistrar's Signature State 2006 Registrar

			1 - For State Registrar		artment of Health and I	Reg	ene No. 2006	28722
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     MANUEL     4a. Facility Name (If not institution, give s	GRI	ETSKY  4b. City, Town, or Location of Death	2. Date of Death Month AUGUST 2	Day Year 24, 2006	3. Time of Death 7:50 A M
9	Funeral Director		MONTGOMERY GENTERA  5. Social Security Number  032-26-5967  6. Sex		OLNEY  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	MONTGO	ace (State or Foreign
	0	tor	Usual Residence of Decedent  10a. State 10b. County  MD MONTGO	10c. City, Town or Lo	SILVER SPRING	MARCH 17,		Od. Inside City Limits  1 ★ Yes 2 □ No
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 le marked other than "netural; or items 23e or 28e-f ehow enty injury per	eted by Funeral Director	10e. Street and Number 3100 NORTH LEISURE	E WORLD BLVD. #715  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	10f. Zip Code  20906  Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerting Yes, Specify:  dent's Usual Occupation kind of work done during most of work done during most of work.	Decify Yes or No- o Rican, etc.)	Citizen of What Count  U • S • A  14. Race - America Black, White, e  Specify: WH  D. Kind of Business/Ind	• an Indian, stc.
and 2121	id be filed within on an all Hygiene. Ked other than "I ic event, the Mac	be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) HARRY GRETSKY	College (1-4or 5+)	OWNER  18. Mother's Nam	ne (First, Middle, Mai		G
Baltimore, Maryland	it. Pages 1 and 2 shoul ritment of Health and Me ritant: If Itam 27 le mark njurk geother traumati	To	19a. Informant's Name/Relationship (Ty) HEIDI MORSE/DAUGHT  20a. Method of Disposition 1 ⊠ Buriai 2 □ Cremation 3 ⊠R: 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	CER 3100  amoval from State 20b. Place of Dispo cemetery, cref SHARON ME	N. LEISURE WORLD sistion (Name of matory or other place) EMORIAL PARK 08/27	BLVD#715 , Date 2007/2006 SH	SILVER SP SILVER SP Location - City or Tow ARON, MA	RING, MD wn, State
	Physician /Medical		( CAROLA)	cations that caused the death. Do not ent le cause on each line.	2. Name and Address of Facility ANZANSKY—GOLDBERG L 70 ROCKVILLE PIKI er the mode of dying, such as cardiac	E, ROCKVIL	LE, MARYLAI	NC • ND 20852 Approximate Interval Between Onset and Death
8760,	Examiner	Ical Examiner	Sequentially list conditions, The body Common and Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  The to (or as a consequence of):  Due to (or as a consequence of):				
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
	w requires thet the been signed by should be detact	by	Pan II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	1 🗆 Yes	co use contribute to the	1 -
Vital Records,		Be Completed	25. Was case referred to medical		26. Place of Deal	24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of
Division of V	Phys this ral dia	ertification: To E	27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 2 ER/Outpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		ome 5 Residence 28d. Describe how in	e 6 ⊡Other (Specify) njury occurred	
DİVİ	in Direct	O	3 Suicide 4 Homicide  29a. Certifier (Check only) 2 Medical Examin	28e. Place of Injury - At home, farm, str building, etc. (Specily)	occurred at the time, date and place	and due to the cause	e/s) and manner as sta	tod
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29b. Signature and fittle of contriber	er: On the basis of examination and/or in- and manner stated.	29c. License number		and place, and due to to be bate signed (Month, D. A. H. O.	
	V		30. Name and address of person who core Moth Wew M. (Aud.) 31. Date filed (Month, Day, Year).	mpleted cause of death (Item 23a) (Type,  VW                                32 negistrar's Signature		le Olur	y, MD	20832
	Sta Registr	_	AUG 25 20	06 Breves B. Sp	relie			

#### 06-06502 Paul M. Green

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Death	Reg. No.	16 2072
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)     PAUL M. GREEN		2. Date of Death  Month Day Year August 30, 2006	1000 hrs
j	4a Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Frederick	Death 4c. County of Death Frederick	h
Funeral Director	220-19-7727 1 <sup>X</sup> M 2 F	(In yrs. last birthday) 20 Yrs If Under 1 Year If Under Months Days Hours	Min. Forei	rthplace (State or gn puntry) MARYLAND
w any	Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Location		10d Inside City Limits 1 X Yes 2 No
the Maryland or 28a-f show any iffed at nee.  Director	MARYLAND HOWARD  10e. Street and Number	LAUREL 10f. Zip Code	10g. Citizen of What Cou	
ith the N 23a or 2 n tified		20723  Ever in U.S. 13. Was Decedent of Hispanic Origin	UNITED STATES	OF AMERICA
72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be n effed at once leted by Funeral Director		X No 1 Yes 2 X No specify:	Puerto Rican, etc.) White, etc.	WHITE
5-0036 ed within 72 hours aft bygiene. other than "natural" the Medical Examine Completed by		during most of working life, DO NOT us		/Industry
21215-0036 hould be filed within 72 hound be filed within 72 hound Mental Hygiene. is marked other than "nat rife event, the Medical Exa. To Be Completed			Name (First, Middle, Maiden Surname) OSELEE VICTORIA CRAMER	
ore, MD 212 es 1 and 2 should b of Health and Men If item 27 is man ther traumatic eve	19a. Informant's Name/Relationship (Type, Print )  DAVID GREEN - FATHER	8729 CASTLEROCK COURT	·	
Baltimore, MD 2	20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from Stat  4 Donation 5 Other Specify:	MT. LEBANON CEMETERY	Date 20c. Location - City or 09/03/06 ADELPHI, M	1ARYLAND
Baltimo	21. Signature of Euneral Service Licensee		HINES RINALDI FUNERAL HOME E AVE, SILVER SPRING, MD 2	
Physician /Medical Examiner	23a. Part in Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consection)	intoxication	diac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions, b			
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consection)			
e execurion and rial - tra			06 TT	
	IF FEMALE: 23c. If yes, outcom	e of pregnancy  2 Fetal death 3 Ectopic p	23d. Date of deliver	y Day Year
P.O. Bcs that the deargned by the a detached for the by the best of the by the by the by Physe		but not resulting in the underlying cause given in Part		the cause of death?
cords, law require has been single 2 should be noted			24a Was an 24b Were au	utopsy findings available completion of cause of
ital Resident: The sectificate rector, page	25. Was case referred to medical examiner?	26 Place of Death (Cont 2 Place of Death (Con	Check only one)  Nursing Home 5 Residence 6 Othe	or:
ing Physician: Sing Physician: After this certif funeral director.	27 Manner of Death 28a Date of Injur	ry 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	···
Division o spital or Attending hours after death uneral Director: Afty filled in by the fune Centification:	Pending Accident Suicide Homicide  Pending Investigation Could not be determined  Specify  Pending Investigation Could not be determined  Specify	/2006 Find 8:45 am 1 Yes 2 X hury - At home, farm, street, factory, office building, etc.	uik	ural Route Number, City an Rd.
To the Hospital within 24 hours To the Funeral completely filled		knowledge, death occurred at the time, date and place nination and/or investigation, in my opinion, death occur	e, and due to the cause(s) and manner as star	
To cor	and manner stated  29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo	
	30. Name and address of person who completed cause of de	eath (Item 23a)	August 31, 2006	, 
Stat	Pamela Southall, MD Assistant Medical  31. Date filed (Month Per Year) 6 2006 32. Registrar	Examiner 111 Penn Street, Baltimore	, MD 21201	
Registra	SEP U D ZUUD	and the following		1

Amended Item 1 per Physician 08/28/2006 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 28724 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARY BARBARA GRIFFITH 3. Time of Death Physician Month 2006 August 0830 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 ☐ M 2 🕱 F Director 334-05-2458 91 Dec 02 MICH Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or Itama 23a 250 St. Luke Circle Apt 607 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No þ Specity. Specify White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Rice Anna Schillings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Za Code) Cacapon, 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Helen Herlocker/daughter P.O. Box 535 648 Sideling Mt. Trail W.Va 25422 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/28/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signafure of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) use as the burial-transit and Due to (or as a consequence of) ours after death. neral Director: After this certificate has been signed by the attending physiclan filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy . ∠ Yes 2 No 9 □ Unknown in the past 12 menths? Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2[ 1 Detient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a. To the Funeral D 29a Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier

WIL 3

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

death

filed within 72 hours after

21215-0036

Maryland

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature Glave & Sparke

rson who completed cause of death (Item 23a) (Type, Print) Yousuf Gafar, MD 555 South Center Street Westminster, MD

		i	For Stata Registrar	State of I	Maryland / Dep Ce	ertificate of		Mental Hyg	iene eg. Na 2006	28725
			Negistrar     Necedent's Name (First, Middle,	Last)		Timodio or		2. Date of Dea	th	3. Time of Death
	Physici		Judith	Ann	Hayhurst			August	22, 2006	12:30 P <sub>M</sub>
	/Medi Examir		4a. Facility Name (If not institution,	-		4b. City, Town, o			4c. County of De	ath
			135 Chapel Bra			Hebro			Wicomi	
	Funeral Director		507-56-2629	6. Sex 7.	Age (In yrs. last birthda) 62 Yrs.	Months Days	If Under 24 H Hours Mi		9. B 44 N	inthplace (State or Foreign Country) ebraska
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	.ocation				10d. Inside City Limits
	Maryi f sho	ō	Maryland Wicon	nico	Hebron					Maria Yes 2 No
	r 28e	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	Country?
	238 o		135 Chapel Bra	anch Drive		2183	30		USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If Items 27 is merked other then "natural", or Items 23a or 28e-f show or other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force ad 1 Tes 21 If Yes, Give Year or Date	os? ☑ No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? an, Mexican, Put Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: 1	
5-0	72 ho	eted	15. Decedent's	s Education grade completed)	(Giv	edent's Usual Occup	during most of w	vorking	16b. Kind of Busines	s/Industry
7	Athin 199.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retired	d)			
2	Hygie Hygie Ther ti nt. In		12 17. Father's Name (First, Middle, L	ast)	Lo	an Process		ame (First, Middle, I	Wells Fa	argo
Maryland	2 should be filed within n and Mental Hygiene. I se marked other then 'reumatic event, the Me	To Be	Roy Vernon Dwin					n Florenc		
Man	Ith and Ith and Ith real		19a. Informant's Name/Relationsh  James H. Hayhui			_			; City or Town, State, , MD 21830	
Baltimore,	es 1 ar of Hea f Item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		20b. Place of Disp	oosition (Name of ematory or other place	ce)	Date	20c. Location - City o	r Town, State
ij	Pag ment tent: I		`4 ☐ Donation 5 ☐ Other (Sp	ecify)	Salisbur	y Cremato	and the second	26/06	Salisbury	
Ball	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any Injury or other treu		nature of Funeral Service L	icensee	SESP	HÖIITWAY 501Snow i	Funeral Hill Rd.	. Home Pro , Salisbu	fessional ry, MD 218	Association 304
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause on each	sed the death. Do not e	nter the mode of dyir	ng, such as card	iac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	-	aucev				Oliset and Death
	/Medical Examiner				as a consequence of):					
	ed isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or Fijusy that initiated events	b. Due to (or	as a consequence of):					
,	sicien end burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
8760,	ate be ohysicie the bur	dicai		d						
Box 6	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	elivery Day Year
ds, P.O.	uires that the signed by ald be detacted	by	Part II. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause giv	en in Part I.			to the cause of death?  Probably 4 (Junknown
Vital Records,	The law requiete has been page 2 should	Completed						24a. Was a autops perforr	ned? prior to death?	autopsy findings available completion of cause of
ta		0	25. Was case referred to medical				26. Place of D	eath (Check only on		3 2 110
of V	dis d	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inpa	atient 2 ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing	Home 5 Heside	ence 6 Other (Sp	ecify)
0	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of I (Month,	njury 28b. Time Day Year) Injury	Wor	k?	28d. Describe ho	ow injury occurred	
Sio	tendl death. for: A the fu	icati	2 Accident investigation in Suicide 6 Could no	ation	Injury At home form a		Yes 2 □No	28f Location (St	reet and Number or F	Rural Route Number
Division	al or Attend after death I Director: , d in by the f	Certification;	4 Homicide determin	289. Place 01	Injury - At home, farm, s etc. (Specily)	treet, factory, office		City or Town		Wai Nobie Noribei,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attercompletely filled in by the fune.	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be xaminer: On the basis and manner	ost of my knowledge, dea s of examination and/or stated.	ath occurred at the tir nvestigation, in my o	me, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mor	
	08		paper	27		94	1094		8124	106
	90		30. Name and address of person w	no completed cause of	of death (Item 23a) (Type	o, Print)	5	ALISBUR	8/24 4 MD 2	1804
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 4	2006 Soci	strar's Signature	artes				

		For State		int in Black In Iaryland / Depa <i>Ce</i>		lealth and M	lental Hy		28726
Physicia	n.	Registrar  1. Decedent's Name (First, Middle, Las  Henry Irwin	st)				2. Date of De		3. Time of Death 06 0836 AM
/Medica		4a. Facility Name (If not institution, give	street and number	-)		r Location of Death	1,1	4c. County of De	alh
the state of	en.	1 1-110	ospital		East	Under 24 Hrs.	0. Data of Sin	Talbo	inthplace (State or Foreign
Funeral Director		222-16-1686	9x	ge (In yrs. last birthday) 77 Yrs.	Months Days	Hours Min.	8. Date of Bir Month Da May 31	y. Years	ryland
fand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
Mary	tor	Maryland Carolin	е	Greensbo	co				1X Yes 2 □ No
or 28	Direc	10e. Street and Number			10f. Zip Code		:	10g. Citizen of What (	Country?
aath w	Fall	*	pt 3A 12. Was Deceden	t Ever in 11 S 13	Was Decedent of h		ecify Yes or No	USA 14. Race - An	
1215-0036 within 72 hours after death with the Maryland and: then "natural", or items 23s or 28s-1 show then "natural", or items 13s or 28s-1 show its Medical Exercities must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	Amed Forces 1 Yes 2 If Yes, Give Year or Dates	1051 52	If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Canada	white with the wind t
15-0036	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	(Give	edent's Usual Occup a kind of work done DO NOT use retire	pation during most of work d)	ang	16b. Kind of Busines	s/Industry
- 0	E O	Elementary/Secondary (0·12) 11	College (1-4or		nter			residenti	al
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Be C	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
arylan should be nd Mental i marked o	2	Roland Towers Ir		ADI: 14-17		Lavonia			Zin Code)
(C) 21 2 0 2		19a. Informant's Name/Relationship (	-	204 I	ng Address (Street N. Iniversit	v Ave. Fe	deralsh	er, City or Town, State	and 21632
har teal		20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - City	
MOI Pages ent of mt: If I		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi				Cm 09/0	01/06	Hurlock, N	Maryland
Baltimore, permit. Pages 1 at Department of Hee Important: If Item eny injury or oths once.		21. Signature of Funeral Service Licen	- Pul		2. Name and Addre		ein Fur	eral Home, 21639	PA
		23a. Part1. Eger the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not en	nter the mode of dyn	ng, such as cardiac	or respiratory a	irrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Vent	is a consequence of):  ARD(AL  as a consequence of):  ARY ATT	sorty R	mas			I have
Examiner		Sequentially list conditions	b. Mya	CARDIAL	INPAR	ction			2dys
po is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 🗤 (or a	as a consequence of):	400	110000			1.215
60, be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. CO/O/ Due to (or a	as a consequence of):	rug o	users	-		945
760, e be ex sician	7		d.					401	
687 titicate og physi	fedic				-		-		WARRIED
Division of Vital Records, P.O. Box 687( To the Hospital or Attending Physicien: The law requires that the death certiticate to within 24 hours effer death.  To the Funeral Director: Atten this certiticate has been signed by the attending physicompletely tilled in by the tuneral director, page 2 should be detached for use as the both the completely tilled in by the tuneral director, page 2 should be detached for use as the both the completely tilled in by the tuneral director.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify) _	ey		23d. Date of d Month	lelivery Day Year
ds, P.	þ	Part II. Other significant conditions of DiAbetes m			underlying cause gr	ven in Part I.		tobacco use contribute Yes 2 □ No 3 🗹	to the cause of death?  Probably 4 □Unknown
Division of Vital Records, or Attending Physicien: The law requirest after death.  Director: Atten this certificate has been signed in by the tuneral director, page 2 should be of the base of the ba	ompleted	Chronic obst			rex clise	esse	24a. Was auto perf 1 Yes	ormed2 prior to death	autopsy findings available o completion of cause of ?
f Vital Reysiclen: The Is certiticate his director, page	O	25. Was case referred to medical				26. Place of Dea			
of V hysici his ce	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa		ent 3 DOA			idence 6 Other (S	pecify)
on of ding Ph. Atter th	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. Time Day Year) Injury	Wo	ork? □Yes 2 No	280. Describe	how injury occurred	
Oivisic or Attend of Attend of the death blrector: in by the lin	ertification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of I	Injury - At home, farm, s etc. (Specify)			28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
DIVISION To the Hospital or Attenvihin 24 hours efter deat To the Funeral Director: completely tilled in by the	Medicai Ce	29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Exam	nysician: To the be miner: On the basis and manner	st of my knowledge, dea of examination and/or i stated.	ath occurred at the ti nvestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and manner , date and place, and c	as stated. ue to the cause(s)
o the	Mec	29b. Signature and title of certifier	011			ise number		29d. Date signed (Mo	
- 5 - 6		> Muhael	1 the	- ms	D	31867		8/19/0	6
		30. Name and address of person who							
		Michael J. Fisher		L Idlewild . strar's Signature	Ave. East	on, Maryl	and 216	001	
Sta * Registr		31. Date filed (Month, Day, Year)	106 Jan		herte )				

			For State Registrar	State of Ma	•	epartmen <sup>e</sup> Certificate			and M			2006	28727
			Registrar  1. Decedent's Name (First, Middle, I	Last)		Jerincai	5 01 1	Jeani	1	2. Date of De		2000	3. Time of Death
п	Physici		Wilhelmina	J. Jones	5					Month 8	21 Day	2006	4:00p M
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City,	Town, or	Location of	of Death			County of Death	
			2231 Hidden Va	alley Ln.				Spr			Mo	ntgome	ry
	Funeral Director		578-03-6216		e (In yrs. last birth 7 Y		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 1/18/	th y, Year) 191	Coui	place (State or Foreign ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			·				0d. Inside City Limits
	Mary Hed	tor	Md. Montgo	mery	Silve	Spri	ng						1 ☐ Yes 2 📉 No
	th the	lrec	10e. Street and Number			10f. Zip					10g. Citiz	zen of What Cour	ntry?
	ath wi	ral	2231 Hidden Va			20	904				U.	S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinary mat be multified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		13. Was Deced If Yes, spec	ify Cuba	ispanic Ori n, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: bla	etc.
21215-0036	72 hou	eted	15. Decedent's (Specify only highest)		16a. [	Decedent's Usua Give kind of wor	Occupa	ation	t of worku	10	16b. Kir	nd of Business/In	dustry
2	Athin hen.	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	iii. DO NOT us eautici	e retired	) )	G WOIKI	<i>,</i> 9	Co	smetolo	oav
	Hygie ther t	CO	1 0	st)	De	aucici	an	18 Mothe	r's Name	(First, Middle,			791
Maryland	id be ental ked o ic eve	To Be	William Henry							lizabe			
ary	shou and M smar	-	19a. Informant's Name/Relationship			-						Town, State, Zip	_
	and 2 ealth m 27 I		Ramon P. John	son/son		and the second second second		Vall				r Sprin	20904
Baltimore,	I of H		20a. Method of Disposition  ★□Burial 2 □ Cremation 3	☐Removal from State	cemetery	Disposition (Nam crematory or of	her place			ate		cation - City or To	
틅	rtmer rtant:		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service )		Arling	ton Na						ington Mortua	•
Ba	Per Impo		11 auch	rester		411 K∈	enne	dy S	t.,	N.W.	Was		DC 2001
I			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that caused by one cause on each lin	I the death. Do no	t enter the mode	e of dying	g, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- W.	anitio	20							one month
	Examiner		MANAGEMENT AND LANGE	Due to (or as	a consequence of	oment!	0 -						For Vent
	7 -	ner	if any, leading to immediate cause. Enter Underlying	Due to or as	a consequence of	2	0		11 3	1			7 00 3
	acuted ind transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last		eros bero		pro	004	dor	) ism	e		ten years
8760,	cate be executed physicien and the burial-transit	E E	resulting in death, cast	11.	a consequence of	1	intle !		1				Aldo Harre
387	physics the l	dical		d	pertensi U	e eard	i Or O'	2.CHOL	1112	92,00			THING YEARS
Division of Vital Records, P.O. Box (	The law requires that the death certifi ste has been signed by the ettending pege 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pre					2	3d. Date of delive Month	ory Day Year
σ.	that the	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	he underlying ca	ause give	en in Part I.		23e. Did to	obacco us	se contribute to the	ne cause of death?
rds	w requires been signe should be	ed by	Chronic Obs	tructive	Palmon	ary [	1,26	92p		1 🕲 Y	∕es 2□	]No 3∏Prob	ably 4 Unknown
ဝင္တ	law requires been 2 should	Completed	Chronic Ki	dney Di	sease.	Stage 1	4			24a. Was		24b. Were auto	psy findings available inpletion of cause of
Œ	The I	Com		3	1	0				perfo	rmed? 2 No	death?	
<u>ita</u>	certificate rector, peg	Be	25. Was case referred to medical examiner?	Hospital:			1 04		of Death	(Check only o	пө)		
ō	Phys	٦	1 ☐ Yes 2 ♥ No 27. Manner of Death	1 ☐ Inpatie				4 🗆 140		ne 5 Resid		Other (Specif	γ)
on	nding th. : After e tuner	atlon	1 ■Natural 5 □ Pending 2 □ Accident investigat	(Month, Da)	Year) Inj	ury M	Bc. Injury Work	ດ?ົ່ Yes 2 ∐ /		.55. 55361100 1	iow intary	00001100	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not determine	28e. Place of Injudence of Inju	ury - At home, farr c. (Specify)	n, street, factory,	, office		2	8f. Location (5 City or Tox		Number or Rura	l Route Number,
	Hospital     24 hours a     Funeral is setely filled	edical (	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	examination and	death occurred a for investigation,	at the tim	ie, date and pinion, dear	d place, a	nd due to the old at the time,	cause(s) a	and manner as si place, and due to	ated. the cause(s)
	To the within 2 To the complet	₩ W	29b. Signature and title of certifier			290.	License	number			29d. Date	signed (Month,	Day, Year)
•	1		> Margery	X ALCONO	Jahr	D	30	036	1	-	08	123/	2006
	•		30. Name and address of person with	o completed cause of d	eath (Item 23a) (T		6900	0 6	lgros	a Ave.ly	(w)	Wash. Da	2030M
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 5	2006 Registr	ar's Signature	bark	•						

			1 - For Amend Item	25 tate of Maryla				-	_	06	28728
			1. Decedent's Name (First, Middle, I					2. Date of Death Month		Year	3. Time of Death
	Physici /Medic		Bradley William	n Jarman				08			0589 4
	Examin		4a. Facility Name (If not institution, g	rive street and number)	$\alpha$	4b. City, Town,	or Location of Death		4c. County		
				ional Medicar	Center	Sal	Solvey		WIC	ortice	)
	Funeral Director		5. Social Security Number 217–52–2391 Usual Residence of Decedent	. Sex 10 <b>3</b> 5M 2□ F 7. Age (In yr	s. last birthday, Yrs.	) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV 06,	Year) 1949		ce (State or Foreign y) ID
	/land		10a. State 10b. County	10c. (	City, Town or L	ocation				100	d. Inside City Limits
	the Marylar 28a-f ehow	ţċ	MD Wicon	nico	Fruit	land					1 Doyes 2 No
	deeth with the Maryland ma 23a or 28a-f ehow rmust be notified at	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	√hat Countr	<b>y</b> ?
	23e	la l	605 Sharpspoint	Rd.		2182			J	JSA	
0030	be filed within 72 hours after deeth with the Maryla ital Hygiens. dother than "natural", or itema 23a or 28a-f ehov dother than "natural", or itema 23a or 28a-f ehov event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - Americar k, White, et :: Whit	C.
ָה ה	72 ho	ted	15. Decedent's (Specify only highest	Education	16a. Dece	edent's Usual Occu	pation during most of work ad)	ing.	16b. Kind of Bu	siness/Indu	stry
7	within 72 ene. then "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				,,,g	_		
2	filed w Hygier Sther th	ខ	12	-41		Security	7	15: Middle 1		curity	<u> </u>
and	ntal H	Be	17. Father's Name (First, Middle, La	5()			18. Mother's Name	e (First, Middle, N	alden Sumam	θ)	
$\leq$	should nd Men marke umatic	2	Clarence Jarman  19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree	Stella t and Number or Rura	al Route Number	City or Town	State Zin C	Code)
Z Z	s 1 and 2 should f Heelth and Mer Itam 27 is marke other traumatic		Joan E. Jarman/v			rear or conservation	nt Rd., F				
<u>o</u>	S 1 ar		20a. Method of Disposition	20b	. Place of Disp	osition (Name of ematory or other pla	ace)		20c. Location -		n, State
Ē	Pages Iment of tant: If it jury or o		1 ☐ Burial 2 XI Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	nemoval from State			narva 8/25	/2006	Delmar	DE	
Baltimor	permit. Pa Departmer Important any Injury		21. Signature of Funeral Service Li	MS€8	2	22. Name and Addr LOWIS N	ess of Facility Watson Fu	neral Ho	m <sub>\to</sub>	•	
11	20 E E 9		Talaracion	USTA		1618 West	Rd., Sal	isbury,	MD 2180	)1	
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	an Due to or as a cons	equence of):	ense in a mode of dy	ing, such as cardiac	or respiratory arre	est,	1 1	Approximate nterval Between Onset and Death
	Examiner				OSe	PSi.	2				
-	B #	ner	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ( s a cons	equence of):		1				
	te be executed ysicien and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Ker	al	Fai	ure				
, 60,	cien a		resulting in death) Last	Due to (or as a cons	equence of):	0/10	Ann	2.2			
289	physic the t	dical	`	d	rab	046	ПЧас	2213			
C. Box c	The law requires that the death certificat ite has been signed by the ettending phy page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Dat Moi	e of delivery	/ Day Year
7.	that the ded by	, Ph	Part II. Other significant condition	s contributing to death but not r	esulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contr	ribute to the	cause of death?
Records,	n sign	d b	Hepatic	Failure	2, F	neumo	nitis	1 □ Ye	s 2 🗆 No	3 Probab	bly 4 hknown
<u>ဂ</u>	aw requir s been si 2 should	olete	GastroI	tetinal	Bles	ed		24a. Was ar	1 24b. V	Nere autops	sy findings available pletion of cause of
	rsician: The law s certificete has t lirector, page 2 s	mo;	ESAPHAGE	al vara	0 0			autopsy perform	1ed?	death?	pletion of cause of
Vital	artifice ctor, p	BeC	25. Was case referred to medical examiner?	Vario	-		26. Place of Deat				
	Physic this ce al dire	5	1 XYes 2 □ No		☐ ER/Outpatie	SIL SU DOA		me 5 Reside			
Ĕ	Ing P	5	27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time ( Injury	W		28d. Describe ho	w injury occurr	ed	
Division of	Attending Physician: r death. ector: After this certific by the funeral director,	cat	Accident investiga 3 Suicide 6 Could no	t be Geo Blace of Injune A	thome farm s		]Yes 2 □No	28f. Location (Str	reet and Numb	er or Rural	Route Number
<u>≥</u>	or A effer Direction by	Certification	4 ☐ Homicide determin	building, etc. (Spe	ecity)	areat, factory, office	1	City or Town	, State)	or or rigia, r	route rearriber.
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the best of my k saminer: On the basis of exam and manner stated.	(nowledge, dea ination and/or i	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and ma	nner as stat and due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1/ +/	111	29c. Licer	nse number	25	9d. Date signed	d (Month, D.	ay, Year)
)	. 31. 0			6 Cler	A	3 0	00/122	1	Aua	1975	24,200
1	THE	0	30. Name and address of person w	no completed cause of death (I	tem 23a) (Type	e, Print)		•		, , , -	1
	y	1	Steven Hamlet	te 100 E. Ca.	rol Stre	et, Salis	sbark Mid.	21861			
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2	32. Registrar's Sign	gnature	Sparke	sbarr Md.	5 10			
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1852-25-112

		1- State of Marylan State of Marylan		artment of H			giene, Reg. No.	2006	28729
Physic	cian	Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of Death
/Med	lical	CLAIRE KA:  4a. Facility Name (If not institution, give street and number)	HN	4b. City, Town, or	Logation of Dec	AUGUST		2006 County of Death	4:40 p M
Exam	iner	WASHINGTON ADVENTIST HOSPITAL			KOMA PA		46. 0		NTGOMERY
Funera		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)		If Under 24 Hr Hours Mir	s. 8. Date of Birt	h V Year		place (State or Foreign
Directo		182-01-7802 1□M 2NF 89	Yrs.	Months Days	Hours Mil	FEB 3,	1917		PA
land ow		Usual Residence of Decedent           10a. State         10b. County         10c. Cit	y, Town or Lo	ocation				1.	Od. Inside City Limits
Mary 8-feh	to	MARYLAND MONTGOMERY		SILV	ER SPRI	NG			1⊠Yes 2□No
ith the Marylar or 28e-f ehow	Director	10e. Street and Number		10f. Zip Code			10g. Citiza	en of What Cou	ntry?
s 23a	rai	9412 CURRAN ROAD	6 140		0901			U.S.A	
fter de	Funerai	11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 Never Married 2 Married  1 Yes 2 2No	.5. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No arto Rican, etc.)	.   1	4. Race - Americ Black, White,	
rai', o	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		S	Specify:	WHITE
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of w	orking	16b. Kind	d of Business/In	dustry
within ene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		TROLOGIST	,		COST	METOLOGY	7
be filed within 72 hours after death with the Maryland tel Hygiene. d other then "natural", or items 23a or 28e-f show event. The Modical Examiner must be notified as	Be Co	17. Father's Name (First, Middle, Last)	I HELO	INOBOOIBI	18. Mother's Na	ame (First, Middle,			L
should be ind Mente marked umatic ev	10 8	HARRY BRITTNER			LENA S	CHWARTZ			
2 sho		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numbe	er, City or	Town, State, Zip	Code)
T end Health em 27		JOEL KAHN/SON  20a. Method of Disposition 20b. F	lace of Dispo	15TH AVEN		OMA PARK,		YLAND 20 ation - City or To	
Pages Imment of h			emetery, crei	matory`or other place ID MEML GI	ons 08/2	25/2006		•	, VIRGINIA
permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Important: if item 27 ie marked other then "natural", or items 23a or 28e-1 ehoven hypyrocopher traumatic event. Its Medical Examinar must be notified at each injury or other traumatic event.	4	21. Signature of Funeral Service Licensee	22	2. Name and Addres	s of Facility				VIRGINIA
20 20 20 20 20 20 20 20 20 20 20 20 20 2	1	(GOO)	10	DWARD SAG 191 ROCKV	ILLE PII	KE, ROCKV	ILLE	, INC. , MARYL	AND 20852
		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not en!						Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)	five	Nea	el.	forline			
Examine			uence of):						
ם פ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	udrice of).						
ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	uence of):						
cate be executed bhysicien and the burial-transit	dicai E	4							
difficate as the	Medic	U							
ath cer tendir	lan/N	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 2☐Feta	Ideath 3[	Ectopic pregnancy			23	d. Date of deliver	ery Day Year
the de	Physician/Me	1 ☐ Yes 2 M No 9 ☐ Unknown 4☐ Pregnant at time of d	leath 5	Other (specify)				Monar	July 1 out
The law requires that the death certific the law requires that the death certific are has been signed by the attending page 2 should be detached for use as it	by Ph	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause give	an in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?
w requires been sig		Sepsis				10	Yes 2€	No 3 ☐ Prot	oably 4 Dunknown
law requas been as been	Completed	Valvulas Meach	Dis	en		24a. Was		24b. Were auto	psy findings available mpletion of cause of
The The Cate h	Sol	Real ference				perfo 1 ☐ Yes	rmed? 2.20 No	death?	2 No
Or VILA Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  Hospital: 1系 Inpatient 2 ☐	50/0	Othe		eath (Check only o			
9 Phy er this	I	27. Manner of Death 28a. Date of Injury	28b. Time o	IL 3L DOX	4 🗀 (40) Sirily	Home 5 Resident			γ)
endin path. pr: Aft	atio	2 Accident investigation	Injury		Yes 2 □ No				
or Attended the control of the contr	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At h building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (: City or To	Street and vn. State)	Number or Rura	al Route Number.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, deat	h occurred at the tim	ne, date and nia	ce, and due to the	cause/s) a	ind manner as s	tated
he Hoi n 24 h ne Fur sletely	edical	(Cleack with 2 Medical Examiner: On the basis of examiner one)	ation and/or in	ivestigation, in my or	pinion, death oc	curred at the time,	date and	place, and due t	o the cause(s)
To the Tourishing Comp.	Σ	29b. Signature aroutile of certifier	0	29c. License			29d. Date	signed (Month,	Day, Year)
18 2	D	39			5660			8-23	-01
		30. Name and address of person who completed cause of death ter	X	~, I	INDER S	COC.	io	MD	207/1
S Regis	tate strar	31. Date filed (Month, Day, Year) AUG 25 2006 33 Registrar's Signal AUG 25 2006	ture &	anti)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2006 Betty Jane Kaufman /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Talbot Memoria Easton tospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 79 Yrs. 221-18-2945 Director March 4, 1921 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits of 2 should be filed within 72 hours after death with the Marylan ith and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28a-f ehow traumalic event, the Madical Examine must be notified at 1□Yes 2□No Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 320 South Third Street 21629 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS grad Accounting Firm Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Helen Cabeu Raymond Medford Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an, important: If Item 27 ts m any Injury or other. 5832 Bartholow Road, Sykesville, Maryland 21784 Marcey L. Thompson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/2/2006 Denton, Maryland Denton Cemeteru 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ventucular disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 DAK 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 46 1 Anpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Al 24 hours after of 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 August 24, 2000 00053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields, M.D., 219 South Washington Street, Easton, Maryland 21601

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day Year)

Saltimore, Maryland 21215-0036

Box 68760,

Division of Vital

Goods 1

32. Registrar's Signature

William .

			For State Registrar			ite of Ma	arylar		oartme e <i>rtifica</i>				ental Hy	Reg. No.	2006	28	373
	Physicia /Medic	al	1. Decedent's Nam Molly		Ann		rnan		T				2. Date of De Month Aug	Day 23	Zuo 6	3. Time (	of Death
	Examin Funeral	er	4a. Facility Name (  1010SU  5. Social Security N	1a Rec	1009L	med.	ical	Center last birthda	y) If Und	Sa. er 1 Year	If Under	elly 2 Hrs.	8. Date of Bir	U	JUNIC 9. Birthp	ace (State	or Foreign
	Director		198-28-1 Usual Residence		1□ M 2	<b>∑</b> F	69	Yrs.	Month	Days	Hours	Min.	8/10/.	1937	Penns	ÿlvar	nia
ө Магуlал	r 28a-f ahow	Director	Maryland	10b. County Wicor	nico			ty, Town or bron			-			-			City Limits s 2 \( \text{No} \)
th with	23a or 2 ust be n	ai Dire	303 Walr							ip Code 21830	)			10g. Citizer US	n of What Coun A	lry?	
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Baltimore, Maryland 21215-0036	jene. r than "nat i're Mardica	Completed	(Special Special 15. Decedent cify only highes ondary (0-12)	t grade com	oleted) llege (1-4or t	5+)	1	pedent's Us ye kind of y DO NOT eache			st of workii	ng		of Business/Inc .cation	ustry		
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Records, P.O. Box 68	by the attending pt teched for use as t	Physician/Medical	fF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2- 9 □ Unknown	months?	10	res, outcome Live birth Pregnant at Unknown	2 Feta	al death 3	B⊟Ectopic i⊟ Other (i					230	. Date of delive Month	y Day	Year
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ry Kerry Vision of Vital	death. stor: After th the funeral	ertification: 1	27. Manner of Dea 1 Natural 2 Accident	5 Pending investig	g ation	Date of Inju (Month, Da	ırv	28b. Time Injun	of	28c. Injun Wor		2	28d. Describe				
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ha Hoa	within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one)	Certifyin 2  Medical I	=xamıner: 🔾	To the best n the basis o nd manner st	i examina	owledge, de ation and/or	ath occurre investigation	dat the tin	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) an date and pla	d manner as sta ice, and due to	ited. the cause(	s)
	Tot	Σ	29b. Signature and	title of certifier					2	9c. Licens	e number	3		29d. Date s	igned (Month, L	ay, Year)	
N	192		30. Name and add	ress of person	who complete	ed cause of o	leath (Iter		e, Print)=	£			Medica	( ant	- 5al	W.W	cm p
	Sta Registr		31. Date filed (Mor	AUG 2	1 2006	32. Registr	ar's Signi		Inacti	,		1				( J U_	l

Physici	an	1 - For Amend Items Registrar  1. Decedent's Name (First, Middle, La.								2. Date of Do			3. Time of Dear
/Medic		Sofia Smiros K	leinert			,				8-14-		1001	5:10a
Examin	er	4a. Facility Name (If not institution, give		-				Location of	of Death		4c.	County of Dea	
	Щ	Asbury Retiremen			In ad bindbinde is		olon	ions	24 Hee	0.0-4(0.0)	-11-	Calve	
Funeral Director		5. Social Security Number 6. S 132–10–4896	M 2XF	. Age ( <i>in yr</i> s. 86	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di 9-2-19	av. Year)	9. Bi	rthplace (State or For country)
		Usual Residence of Decedent		00						9-2-15	117	rai	nama
Mow T		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Li
1	cto	Maryland Calvert		Sc	lomons	5							1 🗆 Yes 2 🗆
or 26	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What C	ountry?
9 23e	a	11450 Asbury Cir					206				USA		
Department of release and Marked other than "natural", or fleme 23a or 28a-1 show important; it flem 27 is marked other than "natural", or fleme 23a or 28a-1 show any Injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? ☑ No		Was Deced If Yes, spec		spanic Origon, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or Ne Rican, etc.)		14. Race - Am Black, Wh Specify:	
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rked ific e	To E	Costa Smiros						Anto	onia	DePier	0		
and le ma		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City or	Town, State,	Zip Code)
m 27 m 27 her tr		Susan Zierman (D	aughter)	1				Rd. I		y, MD.	206.		
or oth		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐	Removal from St		Place of Dispo cemetery, crer	natory or o	ne of ther place			Date		cation - City or	
tant:		* 4 □ Donation 5 □ Other (Specify		Nat	cional					-2006			cch, VA.
Impor		21. Signature of Funeral Service Licen  23a. Part1. Enter the disease, or comp	Ler	10	74	00 Le	e HW	Y. I	Fa11:	fordabl s Churc	h, V		
ohysicien end IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a conseq							· · · · · · · · · · · · · · · · · · ·		
by the ettending ph tached for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2 ∏Feta nt at time of d	ıl death 3 □	Ectopic pro					2	3d. Date of de Month	livery Day Yea
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should	Completed	@ AD								24a. Was	an	24h Wara a	utopsy findings ava
ete has page 2	E									autor	psy prmed?	prior to death?	completion of cause
certifice rector, p	0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 (No	1 L Yes	2 □ No
2 5	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1   Inp	atient 2	ER/Outpatien	t 3 DO	Othe	-		ne 5 Resi		Other (Spe	cify)
		27. Manner of Death  Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	Sc. Injury Work			8d. Describe			
ector: A	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho	ome, farm, stre	М	1 🗆 Y	es 2□N		28f. Location (	Street and	Number or Ri	ural Route Number,
od in	Cer	- Districte	building	, etc. (Specify	у)					City or To	wn, State)		
i i i i	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the be iner: On the basi and manner	s of examina	wiedge, death tion and/or inv	occurred a restigation,	t the time in my opi	e, date and nion, deat	d place, a	and due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
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To the Funeral Director: A completely filled in by the fi	Med	29b. Signature and title of certifier				200.							
To the Fun completely 1	Med	29b. Signature and title of certifier	Burt	l us		200.		399	20			P/21	tac

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			For State		aryland / Dep	artment of Hea	ith and Me	ental Hygie	ne	20722
			Registrar  1. Decedent's Name (First, Middle, I	.ast)	Ce	Tuncale of De		2. Date of Death	No. 2006	28733 3. Time of Death
	Physici /Medic		Lawrence R. Levi	tan				Month	Day Year 24 2006	6:30 A M
	Examin		4a. Facility Name (If not institution, g			4b. City, Town, or Loca	ation of Death		4c. County of Death	
			9728 Beman Wood  5. Social Security Number 6		ge (In yrs. last birthday)	Potomac  If Under 1 Year   If U	Under 24 Hrs.	8 Date of Birth	Montgomer	y place (State or Foreign
	Funeral Director		267-60-6534	1 <b>⊠</b> M 2□F	65 Yrs.		ours Min.	8. Date of Birth (Month, Day, Yo UNE 11,	1941	NY
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation				10d. fnside City Limits
	Maryli febo	tor	MARYLAND MONTGOM	IERY		POTO	OMAC			1X Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	23a c		9728 BEMAN WOODS	WAY		20	854		U.	S.A.
	er des	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
336	urs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ No Sp	Decity:		Specify: WH	ITE
5-0	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or iteme 23a or 26e-f ehow event, the Medical Examination must be notified at	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupation	a most of workin	g 16	b. Kind of Business/l	ndustry
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e)	1 and Health Im 27		ROSELYN LEVITAN/V		9728 20b. Place of Dispo	BEMAN WOODS			IARY LAND  c. Location - City or 1	20854
nor	nt of h		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery, cre	matory or other place) REMEMBRANC			ARKSBURG,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 Ie marked any Injury or other treumatic ev	2	21. Signature of Funeral Service Lic			2. Name and Address of DWARD SAGEL				THE THE
ä	Per Contraction		Carb ten		1 1	DWARD SAGEL 091 ROCKVIL	LE PIKE.	ROCKVII	LE, MARYL	AND 20852
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cause ly one cause on each i	d the death. Do not en ine.	ter the mode of dying, su	ich as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
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Вох	death certifica e attending ph id for use as th	an/M	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		∃Ectopic pregnancy			23d. Date of deli	•
о. П	0 0 2	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown		Other (specify)			Month	Day Year
Ω.	requires that the de teen signed by the a hould be detached t	Ph	Part II. Other significant condition:	contributing to death I	out not resulting in the u	ınderlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of death?
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<u>~</u>	The law cete has t	Com						performe	d? death?	2□ No
<u>Kita</u>	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		(Check only one)		
	Phys er this eral di	n: To	1 ☐ Yes 2 █No 27. Manner of Death	28a. Date of Inj		III SEIDON   4		e 5 ☐ Residence 8d. Describe how	e 6 Other (Specinjury occurred	ify)
ion	Attending or death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		ay Year) Injury	Work? M 1 ☐ Yes	2 🗆 No			
Division of	o the Hospitel or Attending Physician: thin 24 hours after death. 5 the Funeral Director: Atter this certific impletely filled in by the funeral director,	Certification:	3 Suicide 6 Could no 4 Homicide determine	289. Place of in	jury - At home, farm, st tc. (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	Hospitel 24 hours a Funeral C		29a. Certifier 1 X Certifying	Physician: To the best	of my knowledge, dea	th occurred at the time, d	ate and place, a	nd due to the caus	se(s) and manner as	stated
	n 24 h	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner s	of examination and/or in	ivestigation, in my opinio	n, death occurre	d at the time, date	and place, and due	to the cause(s)
	F 3 0	Σ	29b. Signature and title of certifier	-11 A		29c. License nur DC16			Date signed (Month	
•	8 10		· AHA	AN NO	8			A	JGUST 24,	2000
			30. Name and address of person with DAVID W. POTTERS				WASHING	ION. D.C	20037	
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature			,		
	Registi	ar	AUG 25	LUUO HERELA	~ 15. BD	SAUL!				

State of Maryland / Department of Health and Mental Hygiene 2006 28734 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** CARL RALPH LeVINE 2025 PM AUGUST 17, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Davs Hours 12 M 2 ☐ F Yrs. 368-16-1530 Director NOVEMBER 22,1911 VIRGINIA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle th and Mental Hygiene. ?7 ie marked other than "natural", or items 23a or 28a-1 ehov traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2X No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3148 GRACEFIELD ROAD #501 20904 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injuryes other traumatic event, the Modified Examinations. Black, White, etc. 1 ☑ Yes 2 ☐ No If Ŷes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 Divorced WWII WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JACOB LeVINE MIRIAM KOHEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARL LeVINE - WIFE 3148 GRACEFIELD ROAD #501, SILVER SPRING, MARYLAND 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) KING DAVID MEMORIAL GARDEN 8/20/2006 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service 22. Name and Address of Facility icen ee HINES-RINALDI FUNERAL HOME, INC 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, ettending physicien Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 DIABETES 1 Yes 2 No 3 Probably 4 ☑Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No HYPERTENSION has certificate 2 No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: မှ 1 Yes 2 No 2 X ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28c. fnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel L 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062432 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLLEY C. MEERS, M.D., 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 2006 AUG Registrar

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			State of Maryland / Department of Health and Me  1- State Registrar Certificate of Death	ental Hygien Reg. N	200	6 28736
				2. Date of Death		3. Time of Death
	Physicia		Dorothy S. Mesmer		ay Year 3, 2006	7:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		c. County of Deat	
	LAdilliti	C1	Cilabriat Conton Hagniga of Baltimana			- 7 - 1
	Funeral			Date of Birth	9. Birti	altimore  nplace (State or Foreign  untry)
	Director		577-09-1012 1 M 2 F 91 Yrs. Months Days Hours Min.	(Month, Day, Yea Ov. 8, 19		ington, DC
			Usual Residence of Decedent			
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	a-f-	Director	Maryland Montgomery Silver Spring			1 ☐ Yes 2 🔀 No
	h the	ire	10e. Street and Number 10f. Zip Code	10g. C	citizen of What Co	untry?
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow offeet Examinational be notified at	a	3330 N. Leisure World Blvd. 20906		USA	
	dea ms	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame Black, White	
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21215-0036	ours iral',	d b	3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify III C	
5	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/	ndustry
21		dr.	Elementary/Secondary (0·12) College (1·4or 5+) life. DO NOT use retired)			
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Maryland		Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (		en Sumame)	
ya	should be nd Mental marked o	၉	John Sheehan Mae Co			
lar	and and ie m	6 4	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural in the Information of Print)	Route Number, City	or Town, State, Z	ip Code)
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ore	TE E E		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  Align: 1		Location - City or	Town, State
Ĕ	artment of lortant: If it		4 Donation 5 Other (Specify)  Mount Olivet Cemetery, DC 200	st 29   06   W	ashingto	n. DC
Baltimore,	permit. Pages Deportment of I Important: If its any njuty or o		21. Signature of Funeral Service Licensee Francis Service Licensee Francis Tracking Address of Facility Fig.			,
m	Dep Amy Amy Amy Amy Amy Amy Amy Amy Amy Amy		500 University Blvd,	W., Silve	er Sprin	g, MD 20901
			23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between
	Physician	,	Immediate Cause (Final	Lesico		Onset and Death
1	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	(004		inenth
	Examiner		MALVULAN HEART Disens	92		years
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×	The law requires that the death certifinate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli	very
Box	atte	ciai	in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  1 □ Ves 2 □ No  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  5 □ Other (specify)		Month	Day Year
P.O.	at the de by the a	ys	9 ☐ Unknown 9☐ Unknown			
	res that igned b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds	urres Propre	d by		1 ☐ Yes	2 □No 3 □ Pr	obably 4 Unknown
Records,	w requir been s should	Completed		24a. Was an	24h Were au	toney findings available
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of Vital	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?  Hospital:   Description   2D EB/Outpatient   2D EDA Other.   Description   2D EB/Outpatient   2D EB/Ou		_	11
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Division	l or Attendated after death Diractor:	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta		IZI NODIO INDINDOI,
	To the Hoepital or At within 24 hours after of To the Funeral Diract completely filled in by		29a. Certiflier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the comme	(c) and	ctated
	To the Hoepital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1	d at the time, date a	(s) and manner as nd place, and due	to the cause(s)
	thin 2 the mple	Mec	29b. Signature and title of certifier 29c. License number	29d F	ate signed (Monti	n. Dav. Yearl
	Z Z Z S			1	- '	
	6		1/1 Mollong way . 000	17	09051	LT, 2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  W. A. Riley G. Binc 6701 N. Charlis S	it da	04 mi	20206
				1, 1700	20100	
	Sta		31. Date filed (Month, Day, Year) 2006 32 registrar's Signature			
	Registi		A STATE OF THE PARTY OF THE PAR			

State of Maryland / Department of Health and Mental Hygiene 200628737 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MORRIS MARKOFF AUGUST 22, 2006 1:48 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL
If Under 1 Year If Under 24 Hrs. LAUREL REGIONAL HOSPITAL PRINCE GEORGES 8. Date of Birth (Month, Day, Year) 10/30/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**□M 2□F Months 87 Yrs. Director NY 102-09-1246 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "neturel", or items 23a or 28a-f ehow with jury occliner traumatic event, the Modical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No MARYLAND Directo MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12220 GALWAY DRIVE 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Š 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER PROGRAMER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) "UNKNOWN" MARKOFF "UNKNOWN" "UNKNOWN" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TILLIE SILVERSTEIN MARKOFF/WIFE 12220 GALWAY DRIVE, SILVER SPRING, MARYLAND 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State NATIONAL CREMATORIUM 08/24/2006 4 ☐ Donation 5 ☐ Other (Specify) FALLS CHURCH, VIRGINIA 21. Signatus uneral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, Approximate Interval Between Onset and Death the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. Lit it only one cause on each line. Immediate Cause (Pixal disease or condition Physician SEPTIC SHOCK /Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2∏ No 1 ☐ Yes 2 ☑ No 1 TYes 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Shpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Mospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours 29a. Certifier 😢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01 D500412 AUGUST 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE PATUXENT PARKWAY #200, COLUMBIA, MD 21044 NATESA P. SHANMUGAM, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Contificate of Death Jamie Renee McChahan

2006 28738

		- For State Registrar		Ce	rtificate o	T Deat	n				g 110.		0 20	10	
Physici Medical Exam	an/	Decedent's Name (First, Middle,     Jamie Rene Mo			Month Day Your							3 Time of Death 2022 hrs			
		4a. Facility Name (if not Institution, 701 Cathedral Street A)	give street and nur	nber)		4b. City, Town, or Location of Death 4c. Coun Baltimore									
E			last birthday)									$\dashv$			
Funeral Director		,				Month		Hours	Min.			Foreign	ntry)		
211053101		218-13-5929 Usual Residence of Decedent	1 M 2 X F	26	Yr	5.			July 29, 1980   County) MD						
any	H	10a State 10b. County		10c. City	, Town or Loca	ation						Т	10d. Inside City Li	imits	
<b>*</b> .		MD		Ra Ra	altimore	<b>a</b>							1 X Yes 2	No	
Maryland 28a-f show d at once.	cto	10e. Street and Number				10f. Zij	o Code		-	10	g. Citizen of Wh	at Count	ry?		
ith the Maryland 23n or 28a-f sho notified at once.	Dire	701 Cathedral	Street				2120	)2			USA				
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		11. Marital Status		edent Ever in l					in? ( Specify Puerto Rica	Yes or No-	14. Race White		an Indian, Black,		
death or iten	Funeral	1 X Never Married 2 Mar	1 Yes	2 X No		_	_		, uorto Rica	, 0.0.7				Į	
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Me Me	O B	19a. Informant's Name/Relationshi									ber, City or Tow	n, State,	Zip Code)		
MD d 2 sho tth and a 27 is		Debora Ziemski/	Mother				_			urg, 1					
feal feal		20a. Method of Disposition  1 Burial 2 Cremation		om State	Place of Dispo crematory or o	other place	9)		Da		20c. Location -				
MO Pages lent of int: I		4 Donation 5 Other Spe		Ca	rroll (	Crema	tion,	Inc	9/01	/2006	Hampst	ead,	, MD		
Baltimore, permit Pages   a Department of He Important: If ite injury or other to		21. Signature of Funeral Service L			27 Pi	Name and	Address of	of Facility	Home a	and Ch	napel, E	.A.	05.5==		
		23a. Part I. Enter the disease, or o	1-		41	12 Wa	shing	ton	Road	Westr	ninster,	_MD	21157	tenvol	
Physician		23a. Part 1. Enter the disease, or of failure. List only one cause of	n each line.					ucn as ca	ardiac or res	piratory arre	est, SHOCK, OF N€	al l	Approximate Int Between Onset		
/wedical		Immediate Cause (Final disease			nine) int	oxicat	ion						Death		
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687 ertifica ding p	ian/l	23b. Was decedent pregnant in the past 12 months?	Live		de ath	Fetal deatl	-	Ectopic	pregnancy		Month	D	ay Year	r	
eath c atten	sici	1 Yes 2 No 9 V Unki		nant at time of o	deatri 5 (	Other (Sp	ecify)								
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tal Records  cian: The law requi certificate has been	ပြီ	25. Was case referred to medical		<del>-</del>	<del></del>	_	26.Place	of Death (	(Check only			<u> </u>	"		
/ita /siciar iis cert	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3		Other <sub>4</sub>	Nursing H		Residence 6	✓ Other	: Scene		
of Vi ing Physi After this	٦	27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time o	of Injury	28c. Injur	y at Work	? 280	d Describe I	how injury occur	red			
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pital o	Certification:	4 Homicide deter	mined (Specify)		_				- 1	Baltino	<u> </u>				
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attenti	le3	Tomoun only	nysician: To the be niner:On the basis	st of my knowle	edge, death oc	curred at t	he time, da ny opinion	te and pla	ace, and due	e to the caus e time, date	se(s) and manne and place and	r as start due to th	.ed. e cause(s)		
To th within To th	Medical	29b. Signature and title of certifie	and manner:				9c. License						nth, Day, Year)		
_	2	230. Signature and title of certifie	// /				O.C.N				August 31		, = = 3, , 001/		
and		Yante Tour	Hall MI	Ino of decth /"	am 23a\										
30. Name and address of person who completed cause of death (Item 23a)  Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201															
JO_	State		32. R	gistrar's Sign		_									
Regi		SEP 0 5	2006	low	N. A	234	,								
DHMH 17 Rev 1	/2001		-		ORIĞIN	IAL									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Barbara Winifred Newkirk Metzger August 23, 2006 0645 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec 4, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 1 F 82 Yrs. 382-14-1656 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Maryland Carroll Westminster 15 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Bella Vita Court, Apt 1C 21157 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Motel Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I should be Julia Winifred Wilson Birkett Filmore Newkirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Michael Pearl, son 106 S. Hollings Ferry Road, Ferndale, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/24 20a. Method of Disposition 20c. Location - City or Town, State Department of H important: If ite eny injury or ot once. 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Winfield, MD South Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee M01191 word 91 Willis Street, Westminster, MD 21157 tair 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL **Physician** INFARCTION disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnapt 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ğ in the past 12 mont Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Division of Vital Records, Š certificate has been signe rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease, Completed hypertension, Coronary artery 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification, 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 PER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide ō within 24 hours at to the Funeret D completely filled is Hospitel 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ihe B 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL H5393 >26° eno 8HVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 218 Washington Heights Medical Center, Westminster Manoel DO: 31. Date filed (Month, Day, Year) 32. Regigrar's Signature MO 21157 State Registrar AUG 2 5 2006

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Majors 22 2006 8:38 AM August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Wicomico Nursing Home Salisbury 8. Date of Birth (Month, Day, Year) 6/3/1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 84 Months 1 □ M 2 □X Connecticut 217-14-8248 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland theatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?7 Is marked other than "natural", or ltams 23a or 28e-f show traumatic event, the Medical Exar is at inual by notified at 1 XYes 2 No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 228 Canal Park Drive 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Holbrook Ralph G. Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lypartrient of Health an Important: If item 27 Is m any injury or other 2006. 228 Canal Park Dr., Salisbury, MD 21804 Joyce Hall/daughter 20b. Place of Disposition (Name of cometery, crematory or other place Mardela Memorial Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) 8/26/06 Mardela Springs, MD 21. signature of Funeral Service 2Horloway Stufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Party Enter the disease, or complications that caused be shock, or heart failure. List only one cause on a chief. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisass or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performy 24b. Were autopsy findings available prior to completion of cause of death? certificate has director, page 2 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA <sup>o</sup>L 1 ☐ Yes this 28d. Describe how injury occurred filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Thomicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -00 605/5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 21804 614 Easternshore Dr Maesha Thimmarayappa M.D. 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2006 Registrar

			1 - For State Registrar	State of M	arylar	nd / Depa	artme rtifica	nt of H te of L	ealth a	and M	ental Hy	giene Reg. No	2008	5 287	41
	Physicia	an	1. Decedent's Name (First, Middle	, Last)							2. Date of De	ath	2006 <sup>Year</sup>	3. Time of Dea	
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	Funeral			6. Sex 7. Ag	je (In yrs.	last birthday)	If Und	er 1 Year	If Under		8. Date of Bir	th	9. Bi	thplace (State or Fo	oreign
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	w w	ł	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						·	10d, Inside City L	imits
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	r 28a	Director	10e. Street and Number	mery	Der	nesua	10f. Z	ip Code				10g. Cit	izen of What C	ountry?	
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	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	1	J.S. 13.	Was Dec	edent of Hi ecify Cuba	spanic Orig	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
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3	2 hour		15. Decedent	's Education		16a. Dece	dent's Us	ual Occupa	ation			16b. K	ind of Business	hite	
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چ	hould d Mer marke	2	Pedro Ramon Maa  19a. Informant's Name/Relationsh			19b Mailie	ag Addre	es (Street s			elena S		a Town, State,	Zin Code)	
<u> </u>	od 2 sulth an ulth an 27 ts		Pedro Maal/son	15 (1)50, 11110			_					•		Republic	
ā,	is 1 and 1 a		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	ame of	e)	Di	ate	20c. Lo	ocation - City or	Town, State	
Ĕ	Page nent c ant: If ury or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp			esapeak	-		1	08/25	5/06	Be1t	sville	, MD	
Saitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.  Timportant: If tien 27 is marked other then "naturel" or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service L	icensee/		GC	Name a	and Addres Home	s of Facility	y ation	ı Servi	ce	P.O. Bo	ox 784	
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			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each li	ne.	in. Do not ent	er the mo	ade or ayıng	g, such as	cardiac of	respiratory at	rest,		Approximate Interval Betwee Onset and Deat	
	Physician /Medical		disease or condition resulting in death)	a. Respira			ire								
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, D	w requires that the death certific been signed by the attending p should be detached for use as i	d b	Part II. Other significent condition  Lyme Disease	ns contributing to death b	ut not res	suiting in the u	naeriying	cause give	n in Paπ I.			/es 2	_	o the cause of death robably 4 □Unkn	
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	ospits hours uneral ly filled		29a. Certifier 1X Certifying (Check only 2 ☐ Medical E	g Physician: To the best	of my kno	owledge, death	occurre	d at the tim	e, date and	d place, a	nd due to the	cause(s)	and manner a	s stated.	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29b. Signature and title of certifier	Examiner: On the basis o and manner sta	ated.	and and or in		n, in my op 3c. License							
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. ~			30. Name and address of person v	who completed cause of c	leath (Iter	n 23a) (Type,		61630	,		A	ugus	st 21, 2	2000	
Ø	)		Shishir K. Khet	an, M.D. 120	01 Se	even Lo		Rd. S	Suite	111	Rockvi	11e,	MD 208	354	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Figistr			La. M								
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				State of Maryland / Department of Health and N  1- State Registrar Certificate of Death		giene eg. No. 20	06	28742
				1. Decedent's Name (First, Middle, Last)	2. Date of Deat	th	·····	3. Time of Death
		Physici /Medic		Jean Elizabeth Marvaso	August	26, 200	Year 6	1:35 p.m.
		Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of	of Death	
				Annapolis Nursing & Rehab. Center Annapolis		Anne		
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  5. 70 1 1 5.00 1	8. Date of Birth (Month, Day,	Year)		ace (State or Foreign try)
		Director		579-14-5609 1 M 2 M 83 Yrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. W	April l	17,1923	New	Jersey.
		land ow		10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
		Many ied	ţō	Maryland St. Mary's Lexington Park				1 ☐ Yes 2 📉 No
		ith the Marylar or 28e-f show se notified at	Director	10e. Street and Number 10f. Zip Code	1	l0g. Citizen of W	hat Coun	try?
		death with the Maryland ms 23a or 28e-f show rmat be rediffed at	a a	21895 Pegg Road, Apt. #103 20653		Unite	d St	ates
		r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	ecify Yes or No- Rican, etc.)	14. Race Black	- America c, White, e	
	36	s afte	by Fi	If Yes, Give 1		Specify:	Whi	te
	8	hour ture	edb	3Å Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bus	siness/Inc	lustry
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	212	d with	E O	12 Homemaker		Own H	ome_	
W	Pu	al Hyg	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, i	Maiden Surname	a)	
3	Maryland 21215-0036	Menta Menta Brked	10	Carl Knighten Mae K	nighten			
0	lar	2 sho and Is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run				
9		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23s or 28e-4 show any injury or other treumatic event, the Medical Examinal must be notified at once.		Maria English / Daughter 23247 White Birch Cour		Califo		
	Baltimore,	ges 1 It of H If its or ot		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State			,	
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axed	Ba	permi Depar Impo any ir		1911				
Jo				Ky1e S. Simons M01206 22955 Ho11ywood Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			_MD :	Approximate
				shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
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7	Re	Physicien: The law r this certificate has E ral director, page 2 s	Completed by	Above knee Amportation Right leg	autops perfori	med? d	rior to con eath? □ Yes	npletion of cause of
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	Division of Vital	tding Physicien: th. : After this certifica funeral director, f	ToE	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Reside	ence 6 Othe	r (Specify	)
	ОП	ng Pt		1 □ Natural 5 □ Pending (Month, Ďaý Year) Injury Work?	28d. Describe ho	ow injury occurre		o from
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	Σ	or At liter of Direct in by	Certification;	4 Homicide determined building, etc. (Specify)	City or Town	n, State) 2000	9 Anna	Route Number, pulis Mall
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	6	m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL A. DEVORE MD 4203 QUEENS bury Rd Ho				
	7/	1			1975V	illeMI	) 2	0781
		Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
		Regist	rali	AUG 3 0 2006 Seem & South				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 9:15 098 06 Timothy Michael O'Leary /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice at Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/18/1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Days Min. Hours 1**⊠** M 2□ F 49 Yrs New York Director 132-50-3591 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other then "netural", or items 23s or 28s-f eho Funeral Director 1 ☐ Yes 2 No Virginia Accomac Onancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20293 Deep Creek 23417 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo white ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Event Coordinator Hospitality 17 is marked other treumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If them 27 is marked oth eny lipury or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Paul John O'Leary Betty Pauline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie O'Leary/Wife 20293 Deep Creek, Onancock, VA 23417 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Niagara Falls 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/06 Lewiston, NY Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association W.K. Halloung 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Esquestially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and I for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes -2 ER/Outpatient 3 DOA After thi 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Natural 5 Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the h 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 26278

Registrar

DHMH 17 Rev 1/2001

State

Box 1733 Selish, NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 4 2006

32. Digistrar's Signature

31. Date filed (Month, Day, Year)

		1 - For State Registrar	State of Ma		partment of I ertificate of			Reg. No.	006	287	41
Physici	an	Decedent's Name (First, Middle, L.	•	_ ,			2. Date of D Month	eath Day	Year	3. Time of Dea	th
/Media	cal	Margaret  4a/Facility Name (If not institution, g	Ruth	Parks	4h City Town	or Location of Dea	S P		200 (a	1608	
Examir	ier	10 10	onal Medi	cos Center	5	lisbury			unica		
uneral rector		5. Social Security Number 215–38–1879	. The act -	(In yrs. last birthda	Months Days	If Under 24/Hrs Hours Min		irth Pay, Year) 1941	Coun	ace (State or For try) yland	reign
A ==		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Lin	mits
ortant: if item 27 te marked other than "naturar, or fems 25s or 25s-f anow injury or other traumatic event, the Madical Examiner must be notified at	tor	Maryland Wicom	ico	Salis	oury					1 □ Yes <b>3</b> (□	] No
a not	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	ral	532 Village Cou			2180			USA			
	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ② Divorced	12. Was Decedent E Armed Forces? 1 Tyes 22 N If Yes, Give Year or Dates:	□Yes 2Ã No Yes, Give 1 □ Yes 2ÃNo Specify:				Io- 14. Ra Bla Speci	ace - America ack, White, e ify: Wh		
	ted	15. Decedent's l		16a. De	cedent's Usual Occup ve kind of work done	pation during most of we	orkina	16b. Kind of I	Business/Ind	ustry	
	nple	Elementary/Secondary (0-12)	College (1-4or 5-	⊦) life	. DO NOT use retire	id)	Siking				
	S	17. Father's Name (First, Middle, Las	<del>-</del>	Cler	CK.	18 Mother's No	me (First, Middle	Fast			
	To Be	Handy L. Smull					. Davis	e, walden Suma	1110)		
	1	19a. Informant's Name/Relationship Rev. Martin Hu			uling Address (Street Kearny K	and Number or F	Rural Route Numi			Code)	
		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ice)	Date	20c. Location	- City or To	wn, State	
		1 ☐ Burial 2 🎦 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	ry Cremat	1	3/06	Salisb	oury, l	AD.	
		21 Signature of Funeral Service Lic	ensee	GREATHAN S	22 Name and Addre	Funeral	Home Pr	cofessio	nal As	sociati	on
*		Carrie H. V	Sadmok	CFSP	DOT PUOM	HITT KO	ad, Sali	isbury,	WD 519	304	
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one cause on each lin	the death. Do not a	enter the mode of dyl	n such as cardia	ac or respiratory	arrest,		Approximite Interview tween Ons and Death	i n
		Immediate Cause (Final disease or condition resulting in death)	a	consultance of):	May	Jazit	3-1-			w	
r	il Examiner	Sequentially list conditions, any leading to immodulate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):	It By	na fon	Durt	ress of	-do	a) Nu	75
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No	23c. If yes, outcome of the composition of the comp	2 ☐ Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			ate of deliver	y D <b>ay</b> Year	
	Phys	9 Unknown					-				_
	<u>중</u>	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause give	ven in Part I.				e cause of death	
	eted							Yes 2□No	3 Proba		
	Completed						24a. Was	psy	. Were autop prior to com death?	sy findings available in a system of cause	able of
	င်	25. Was case referred to medical				00 Blood (B		formed? 20 No		2 □ No	
	ToB	examiner? 1 Yes 2 No	Hospital:	it 2 ☐ ER/Outpat	ient 3□ DOA Ott	200	eath <i>(Check only</i> Home 5 ☐ Res		ther (Snecific	1	_
		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day	/ 28b. Time	of 28c. Inju			how injury occu		,	
	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Ptace of Injurbuilding, etc.	ry - At home, farm, (Specify)	street, factory, office			(Street and Num own, State)	ber or Rural	Route Number,	
	dlcal	29a Certifier 12 Certifying F (Check only one) 2 Medical Ext	hysician: To the best of miner: On the basis of and marrier stat	l iny knowledge de examination and/or	ath occurred at the ti investigation, in my o	me data and plac opinion, death occ	e, and due to the surred at the time	cause(s) and in , date and place	and due to	ited. the cause(s)	
	Me	29b. Signature and title of certifier	and majorier star	, au	29c. Licens			29d. Date sign			
		1 /57	1401	5	D 24	447		8/22			
		30. Name and address of person who	completed cause of de		e, Print)						
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ita		31. Date filed (Month, Day, Year)	32 Registra				/				-
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	ar	AUG 2 3	2006	w de	Souls 2						
gisti ev 1/2	ar		2006 See	n &,	Joels -		***				

Amend Items 286, 1 per Mir, 655 per 1729/06 different and Mental Hygiene 2006 Certificate of Death Reg. No. 28745 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 2006 Ernst Robert Pemsel 9:15 A /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9206 Victoria Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 24, 220 26 7400 76 July 1930 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location in than "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 XNo Director Howard Ellicott City 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 9206 Victoria Drive 21042 United States death Funerai Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No within 72 hours after 1 ☐ Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Electrical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of Ernst Robert Pemsel Ethel Fischer ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and at of Hears. at: If itam 27 is Elizabeth L. Pemsel/Wife 9206 Victoria Drive Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or 4 Donation 5 Donation 5 Dother (Specify) entombranent Crest Lawn Mem. Gard. 8-29-2006 Marriottsville, MD M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Den 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOT **Physician** disease or condition resulting in death) LILIN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit DEFINICATION APPROVED BY MEDI Due to (or as a consequence of) pe Physician/Medical the certificate as IF FEMALE Box nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant death c 3 Ectopic pregnancy Day ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown o 9 Hinknown á ۵. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 21/2 No certificate 1 Yes 2 No 1 🗌 Yes Vital Physician: 25. Was case referred to medical exampler? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Ves 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this of 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 Pending investigation 1 Natural To the Hospin...
within 24 hours after death.
To the Funeral Director: Ah Selfinflicited any shot avound 1 ☐ Yes 2√ZNo 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 9206 Victoria Prive Garage 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the lone cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number August 26, 2006 Moran mil of death (Item 23a) (Type, Print) 30. Name and address of person 32. Poistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 21, 2006 Ramirez August 3:45 Sara /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year - If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 95 Yrs. 1910 Director 219-68-6934 Colombia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23s or 28s-1 show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20852 Colombia permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nature." 12109 Lauderdale Drive Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Colombian 1 XYes 2 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrico Ramirez Visenta Ortiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12109 Lauderdale Drive; Rockville, Maryland 20852 Elisa Martinez / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 8/24/2006 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Erfter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Diverticulitis /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, fary, leading to firm ediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consecuence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sepais resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 1 ☐ Yes 2 ☑ No 2 🔀 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Aft completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20056063 August 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7010 Winterberry Lane; Bethesda, Maryland 20817 Kanwaljit Kaur Nagi 31. Date filed (Month, Day, Year) AUG 25 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

	For State Registrer	State of Marylan		nent of H		nd Mental I	Hygiene Reg. No.	2000	28747
Dhysisian	1. Decedent's Name (First, Middle, Last	)				2. Date of Month	Death Day	Year	3. Time of Death
Physician /Medical	John Rusokoff					Auc	10	24,2006	10:30 AM
Examiner	4a. Fecility Name (If not institution, give		46	. City, Town, or	- 1		4c.	County of Death	300
	Salisbury Rehamber 6. Se	X 7. Age (In yrs.	3 Ctr.	Under 1 Year	If Under 24		Righ	Wico	
Funeral Director		x M 2□F 91		onths Days		Min. (Month	Birth Day, Year) -1915	Count	ace (State or Foreign ry) Pa •
	Usual Residence of Decedent					, 10			
how	10a. State 10b. County	10c. City	y, Town or Locatio	n				10	d. Inside City Limits
Ba-f s	Md. Wicomic	o Sa	lisbury						X□Yes 2□No
vith th	10e. Street and Number		1	0f. Zip Code 21804	<i>t</i> .			zen of What Count JSA	ry?
A OFF  336  Its after death with the Mar after death with the Mar after death with the Mar at the most send of the most send	225 Mildale Drive	12. Was Decedent Ever in U.	S 12 W/25			n? /Spacify Vas o		14. Race - America	no Indian
ter de	11. Marital Status  1 □ Never Married 2□ Married	Armed Forces?	If Yes	s, specify Cuba	n, Mexican,	n? (Specify Yes o Puerto Rican, etc.	) 140-	Black, White, e	
D36 036 urs at	XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	Yes 2. Maria Yes	Specify:			Specify: Whi	te
21215-0036 ed within 72 hours after death with the Maryland sygiene. That is not than "natural", or items 23a or 28a-f show it, the Medical Examinations that conflict and Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. Decedent'	s Usual Occupa	ation Juring most o	of working	16b. Kii	nd of Business/Ind	ustry
within within " than " re Me	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	VOT use retired,	)		Cor	rernment	
A B B B B B	8 17. Father's Name (First, Middle, Last)		Inspe	SCEOL	18. Mother's	s Name (First, Mid			
and d be fill the solution of	John Rusokoff					ia Darch		,	
Maryland d 2 should be fill th and Mental H; 7 is marked out traumatic even	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Ad	ddress (Street a				r Town, State, Zip	Code)
_ c in a s	John Rusokoff, So	n	225 Mi	ldale D	rive,	Salisbur	y, Md.	21804	
Baltimore, bemit. Pages 1 at Department of Hea mportant: If item my injury or other page.	20a. Method of Disposition	20b. P	lace of Disposition temetery, cremato	n (Name of ry or other place	e)	Date	20c. Lo	cation - City or Tov	vn, State
Baltimore permit. Pages 1 Department of E Important: If ite any injury or ot	` 4 ☐ Donation 5 ☐ Other (Specify	Rest	ırrectio	n Cem.	8-	-28-06	Upper	r Marlbor	o, Md.
Balt permit Depart Import any inj once.	21. Signature of Funeral Service Licens	see	22. Na Sho	me and Addres	ss of Facility eral H	Home, Inc			
W 005 6 0	23a. Part1. Enter the disease, or comp	terell	13			Delmar,			Approximate
	shock, or hear failure. List only o	ine cause on each line.		• mode or dymi	y, such as co	ardiac or respirato	ry arrest,		Interval Between Onset and Death
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3876( icate be physicis s the bu	•	d							
Box 68760, eath certificate be exattending physician ifor use as the burian clan/Medical Ecian/Medical E	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of deliver	rv
P.O. Box 68 nat the death certifical doy the attending pleached for use as the physician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		opic pregnancy ner (s <i>pecify)</i>			_	Month	Day Year
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IS, Free that res that signed be defined by P	Part II. Other significant conditions co	entributing to death but not res	ulting in the under	lying cause give	en in Part I.			ise contribute to the	
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al Re in The line in page in page						1 □ Y	es 2 Mo	1 Yes	2□ No
f Vital system: T system: T system: T director, pa	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	ER/Outpatient 3	Othe	00	of Death (Check of Sing Home 5 1 1		6 ☐Other (Specify	1
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o the o the comple	29b. Signature and title of certifier	and mariner stated.		29c. License	e number		29d. Dat	te signed (Month, L	Day, Year)
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	30. Name and address of person who o	completed cause of death (Item	n 23a) (Type, Prin	t)	-1-		2	2/00	1
5	William H.T.	Robins M.	D. 20	o Ci	VIC	Ave,	Solis	sbury, 1	MD21804
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					J 1	

		-	For State Registrar		State of Ma	ryland /	Departm Certific			nd Mei		-	2006	2874	8.
	Physici	an	1. Decedent's Name		ismine	Sin	nmon	<	,	2.	Date of Dea Month		Year	3. Time of Death	М
	/Medic Examin	er	4a. Facility Name (If n	ot institution, give s	treet and number)	Lalo	enter 46.0		r Location of E	LY	Date of Birti	4c. (	County of Deat	Georges	5
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	or 28e-	Director	10e. Street and Numb	per				Zip Code					en of What Co	•	
	eath w	erail	705 Pa	aldao Te	err. 12. Was Decedent E	ver in IIS	13 Was D	207		2 (Specifi	y Yes or No-		U.S.A.		
960	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland serment of Heath and Mental Hygiene. fortant: if item 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow injury openier treumatic event, if a Medical Examinar must be notified at injury openier.	by Funeral	1 Widowed 4	2 Married	Armed Forces?  1  Yes 2 No lif Yes, Give Year or Dates:			specify Cuba	lispanic Origin an, Mexican, F Specify:	uerto Ric	an, etc.)		Black, Whit	e, etc.	
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3,2	Sta Registi		31. Date filed (Month		32 Registra	r's Signature	Spelle	9			•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28749 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:25 P <sup>M</sup> Wesley AUGUST 24 2006 LAWRENCE SIMPKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. MARY'S 30095 DUDLEY ROAD MECHANICSVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
July 28, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**∑**M 2□F 92 Yrs. 1914 Maryland 579-03-6813 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No St. Mary's Mechanicsville Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20659 U.S.A. 30095 Dudley Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Tyyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting .. Pages 1 and 2 should be filed w iment of Health and Mental Hygie tant: if Item 27 is marked other t ajury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Wesley Simpkins Lottie Ewell Simpkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine E. Simpkins/wife 30095 Dudley Road Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/28/06 1 

Burial 2 □ Cremation 3 □ Removal from State Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee M00817 P.O. Box 128 Charlotte Hall, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) almontou **Physician** /Medical Due to (or as a consequ Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed take Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) ned by the a o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 1 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificete 1 Yes 2 No 1 Yes 2 No of Vital After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DV6 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation efter death.

I Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel or 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier within 24 hour To the Fune completely file 29b. Signature and title pleted cause of death (Item 23a) (Type, Print)

Registrar

State

Manoj

31. Date filed (Month, Day, Year)

Panwala, MD

AUG 2 8 2006

32. Resstrar's Signature

37767 Market Drive, Charlotte Hall, MD 20622

Amend item 8 per fh. 8864.02/28/07dhb repert of Health and Mental Hygiene 2 0 0 6

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

State of Maryland / Department of Death

Reg. No. 2. Date of Death 08/24/2006 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 06:45 AM SWANSON 2006 STANLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 12/29/19/8/hplace (State or Foreign Months | Days | Hours | Min. | (Month, Pay, Year) | New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 102 M 2 □ F 58 061-42-6028 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No 1-lar+1y DE Directo Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Rd 19953 USA 1318 Tuxward Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Floral Industry Flower Grower 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rider Opal GLenn Swanson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RD, Hartly, De 19953 1318 Swanson Tuxward Sharon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Cutchoque, Cutchogue 8 30 06 Cen. 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses TORBERT FUNERAL CHAPEL DOUGR, DEL, Thelew all orbe Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3DAYS UPPER GI BLEED Due to (or as a consequence of): ADENOCARCINOMA 6 MONTHS PANCREATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physicien use as the signed by page 2 should be certificate After this certification within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

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r then "natural", or items 23s or the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Heelih and Menial Hygiene. Important: if item 27 ie merked other then "natural", or lier any injury or other traumatic event, the Medical Examinat page.

Physician

the Maryland

death

21215-0036

Baltimore, Maryland

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19925 AUGUST, 23, 2006 Yuman , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD-21287 THOOPY PUNNAM, THE JOHNS HOPKINS HOSPITAL , 31. Date filed (Month, Pay, Year)

State Registrar

Medical

	1	For State Registrar	State	of Maryla				Health ar <i>Death</i>	nd Mental Hy	giene 2	006	2875
	£	1. Decedent's Name (First, Midd	le, Last)	· · · · ·					2. Date of De	eath		3. Time of Death
Physicia		MARIAN	Н		SM	1ITH			Avaus	st 23.	2006	4:30 PM
/Medica		4a. Facility Name (If not institutio	n, give street and r	DITE 4.11							nty of Death	
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Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In y	rs. last birthday,	-	der 1 Year	If Under 24		rth		lace (State or Foreign
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pu 🛊	}	Usual Residence of Decedent  10a, State 10b, County		100	City, Town or L	ocation					11	Od. fnside City Limits
anyle sho	ă											1 ☐ Yes 2 No
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death with the Maryland ms 23e or 28e-f show I must be notified at	by Funerai	2710 OLD OCEAN	12. Was De	ecedent Ever in	1 U.S. 13.	Was De		1804 Hispanic Origin	n? (Specify Yes or No	n- 14. R	USA ace - America	an Indian.
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Of V Physic this ce al direc	0	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 [	☐ Inpatient 2	. ☐ ER/Outpatie	nt 3 🗆	DOA Ott	ner: 4 Nursi	ing Home 5 ☐ Resi	dence 6 🗆 C	ther (Specify	•)
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		30. Name and address of person							7/	1	700	4
5		WILLIAM ROBINS				SAL	ISBU	RY, MD.	21804			
State Registra		31. Date filed (Month, Day, Year,		Aggistrar's Sig	gnature	P . A	,					

State of Maryland / Department of Health and Mental Hygiene 2006 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Serafim Diolmar Teixeira 17 2006 0829 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SAUSBURY Under 1 Year | If Under 24 Hrs. Inths Days Hours Min. Date of Birth (Month, Day, Year) 9/11/1950 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 1**∑**M 2□F Brazil Director None Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic avant, the Mudical Examinar must be notified at X Yes 2 No Maryland Wicomico Salisbury Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1020 Margaret St. 21804 Brazil death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after il Hygiene." natural', or Ite 1 Never Married 2 Married Specify: Portugese Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Portugese þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filt Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic avant Be Tereza Fedatto Elagio Serafim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Celia D. Assis/daughter 118 W. Fourth St., Palmyra, NJ 08065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 8/21/06 4 ☐ Donation 5 ☐ Other (Specify) 24. Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 24. 501 Snow Hill Rd., Salisbury, MD 21804 avid Chargemond CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AJCV D 1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes b irector, page 2 sl autopsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ٩ 3□ DOA his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D completely filled in Medical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ag H50497 8/17/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Reg no d Center Salistany Md 7/804 Dr. Chris Snuda 100 Cours St. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 2 3 2006 Registrar

			State of Maryla	ng / Dep		thang Me	ntal Hygie	•	5 28753
Physic /Med		1. Decedent's Name (First, Middle, Last)	Tsirlin	Ilya	Tsirlin		Date of Death Month	Day Year 23, 2006	3. Time of Death 12:45 A M
Exam		4a. Facility Name (If not institution, give s Hebrew Home of 9	reates Woshi	nation	4b. City, Town, or Loca Rockville,		3	4c. County of Deat	
Funera Directo		5. Social Security Number 6. Sew 1 213-43-8241 6. Sew 1 2 1 2 1 3 − 43 − 8 2 4 1		: last birthday) Yrs.	If Under 1 Year   If U	Inder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, You larch 14	9. Birt	hplace (State or Foreign untry) Ukraine
iryfand show		Usual Residence of Decedent  10a. State 10b. County	10c. C	city, Town or La	cation				10d. Inside City Limits
death with the Maryland ms 23a or 28e-f show	recto	DC None  10e. Street and Number	Wa	shingt	On 10f. Zip Code		100	. Citizen of What Co	1 XYes 2 No
th with 23a or	a Di	708 Third Street N.	E.		20002	2		Jnited Sta	
after or Ite	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ☐ Yoo Spe	ic Origin? (Speci exican, Puerto Ri ecity:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
within 72 hours ene. then "neturel; the Mudical Ex.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)	nost of working	16	b. Kind of Business/	industry
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should be f and Mental I marked of matic eve	To Be	Menahem Tsirlin				ertha Ko		oen sumame)	
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Dallimore, Maryliar permit. Pages 1 and 2 should b Department of Health and Menia Important: If tiem 27 Is marked any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e any injury peopler treumatic e		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	20b. emoval from State $Jud$	Place of Dispo cometery, crer lean Mer	sition (Name of matory or other place) NOTIAL	8/25/		Olney MD	Town, State
Galti Dermit. Departm Mporta Nny inju		21. Signature of Funeral Service License	6	22 E 0	Name and Address of I Iward Sagel	Facility Funeral	Directi	on Inc.	
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the dea	10	191 Rockvill	le Pike	Rockwill	6-MD 2085	Approximate
Physician		Immediate Cause (Final disease or condition	1 1	enal	failure				Interval Between Onset and Death
/Medica Examinei	L	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	lerotic	Coronary	arter	y dise	ease,	10 years
<b>BOX 06/00,</b> sath certificate be executed attending physician and for use as the burial-transit	lcal Examiner	Cause Disease or injury that initiated events resulting in death) Last	Du to (or as a conse	squence of):					30 years
· o o o	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of preging the second of	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of del	ivery Day Year
ords, F.C. requires that the de	by	Part II. Other significant conditions con dementia		esulting in the u		Part I.			the cause of death?
VICAL RECOIDS, sicien: The law requires t certificate has been signe lirector, page 2 should be o	Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
ysicien: is certifica director, p	Be	25. Was case referred to medical examiner?	a onital:		2.1	Place of Death (	Check only one)		
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UIVI  De Hospitel or Ai  De Funerel Direct  Defetely filled in by	edical (	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my kr er: On the basis of examir and manner stated.	nowledge, death	h occurred at the time, da vestigation, in my opinion	ate and place, and n, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the To the	M	29b. Signature and title of certifier	1		29c. License num			Date signed (Monti	n, Day, Year)
3		30 Name and address of assessment	moleted course of death ("	am 22a) /T	MD300	146	Ate	gust 23,	2006
/ ٧		30. Name and address of person who co Fris E. Kuhn, mp	6121 Mont	trose	Road Rock	wille,	MD	Z085	2
S Regis	tate trar	31. Date filed (Month, Day, 29ar) AUG 25 200	2000 anistrada Cia	G. Apr	we				

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		- 1	State Registrar	•	C	ertificate of Deat	h	Reg. No.		2010.
		_	Decedent's Name (First, Middle, La	-				te of Death	Year	3. Time of Death
	ysicia Medica		MCKENNE SI	HAY TH	10mP	50N	C		2000	05:53AM
	camine		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location			County of Death	- 0.1
					SPITAL	ROCKVILLE			MONTGO	
	neral ector		5. Social Security Number 6. S	Sex 7. Age (In yrs	s. last birthda Yrs	y) If Under 1 Year If Und Months Days Hours		te of Birth onth, Day, Year)	9. Birth	place (State or Foreign htry) MARYLAND
pu .	55.00	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or	Location			1	0d. Inside City Limits
e Marylan	iffedal	ctor				ANTOWN, M	ARYLAK			1 Yes 2 □ No
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deet	Ē	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mexic</li> </ol>	Origin? (Specify Y can, Puerto Rican,	es or No- etc.)	<ol> <li>Race - American Black, White,</li> </ol>	
urs after	Examin	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Spec			Specify: BU	rck .
72 ho	lical	eted	15. Decedent's E (Specify only highest gr		(G	cedent's Usual Occupation ive kind of work done during m	nost of working	16b. K	ind of Business/In	dustry
ig ig	W.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lif	DO NOT use retired)				
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hould Me	matic	၉	19a. Informant's Name/Relationship		19b. M	ailing Address (Street and Nur		te Number, City o	or Town, State, Zij	Code)
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S 1 ar	othe	10	20a. Method of Disposition		Place of Di	sposition (Name of crematory or other place)	Date		ocation - City or T	
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Baltimor permit. Pages Department of	in in		21. Signature of Funeral Service Lice	nsee		22. Name and Address of Fa	acility		D = 0	1 1 1 1 1 1 1
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/Med Exam	dical		resulting in death)	Due to (or as a cons	equence of):			DAEA	ביישט במח	/
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	s cert	To B	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 XInpatient 2	☐ ER/Outp	Other	Nursing Home		6 ☐Other (Spec	ify)
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Ospital o	led		10000	Physician: To the best of my l	knowledge (	least account at the time dat	to and place, and d	lue to the cause/	s) and manner as	stated
Hoss	Fund tely f	Medical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	aminer: On the basis of exam and manner stated.	ination and/	or investigation, in my opinion,	death occurred at	the time, date an	nd place, and due	to the cause(s)
To the Hospital or within 24 hours effe	To the Funeral Director: Atter th completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. License numb	ber	29d. D	ate signed (Month	, Day, Year)
F ≤ ;	- 0		1 Sunt	1000R, 20, 1	15	163986	ó	9.:	2.06	
			30. Name and address of person wh			/pe, Print)	0 -			
			JONATHON HOD	OR MD, 9901	MEDI	CAL CENTER DRI	ve, Kacki	MUE, N	MARYLAN	D 20850
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*	Sta Regist	ate	31. Date filed (Month, Day, Year)	2006 32. Registrar's Si	gnature	CAL CENTER DRI				

31. Date filed (Month, Day, Year) SEP 1 1 2006

		1- State of Maryland / Department of Healt Certificate of Dea	th and Men ath	ıtal Hygiei Reg.	ne2006	28755
	п	Decedent's Name (First, Middle, Last)	2.1	Date of Death		3. Time of Death
Physici /Medic		Anne Kampelman Wiederkehr	1.		0, 2006	7:42 P <sup>M</sup>
Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati			4c. County of Death	
		Holy Cross Hospital Silver Spr  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea		Date of Birth	Montgome:	
Funeral Director		578-62-2641 1□M 2√□ F 51 Yrs. Months Days Hou	ours Min. (	Month, Day, Ye	ar) Cou 1954 Mar	place (State or Foreign ntry) yland
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
Maryl -f sho	tor	Maryland Montgomery Silver Spring				1 ☐ Yes 2 ☐ No
r 28a	Directo	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	ntry?
death with the Maryland ma 23a or 28a-f show rmust be notified at		1868 Middlebridge Dr 20906		U.	S.A.	
or dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ic Origin? (Specify exican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ameri Black, White,	
rs afte	by F	1  Never Married 2  Married 1	ecify:		Specify:	* * -
2-UU30 72 hours af		15. Decedent's Education 16a. Decedent's Usual Occupation		16b	Kind of Business/In	ite
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d be fill ontail History	Be		Mother's Name (Fir		· ·	
should and Men mark matic	ဥ	Max M. Kampelman Ma  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	arjorie B			2 Code)
Mar 27 la		Dennis E. Wiederkehr - husband 1868 Middlebridge				
DEBILITMOTE, MATYIATIC ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23s or 28s-f show any injury or other traumatic event, the Madeal Exeminational be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		. Location - City or To	
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		23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
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UNISION ( To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town, St	and Number or Rura ate)	al Houte Number,
e Hospital of 24 hours at e Funeral Dietely filled i		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	ate and place, and	due to the cause	e(s) and manner as s	stated.
To the Howithin 24 To the Fu	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.				
with To con	Σ	29b. Signature and title of certifier 29c. License numb	nper	29d.	Date signed (Month,	Uay, Year)
10		furture of series who completed gaves of death (from 22) (Time Brief)		Aug	ust 22, 2	006
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Frederick G. Barr, MD 5454 Wisconsin Ave # 1300	) Ch C	1 M.	aruland of	0015
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Linevy C	nase, m	ararid 7	7013
Regist	rar	AUG 2 5 2006 Steen & Species				

		-	For State Registrar	State of Marylan	•	artment of F		Mental Hyg	iene •g. No. 200	6 28756
			Decedent's Name (First, Middle, Last	st)				2. Date of Deat	th	3. Time of Death
	Physicia /Medic		Abraham Weiss					8 2	23 2006	307A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. County of De	ath
			7710 Seven Locks	Road		Bethesd			Montgome	
	Funeral		5. Social Security Number 6. S	MM 2FF		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	Year) 9. B	rthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	94	Yrs.			9-5-1911	Ne	w York
	land	-	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary -1 eh	ğ	MD Montg	omery E	Bethesd	la				1¾ Yes 2 No
	r 28a	Je C	10e. Street and Number		-	10f. Zip Code		1	0g. Citizen of What 0	Country?
	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or iteme 23s or 28s-f show ent, the Medical Examinar must be inclified at	Funeral Director	7710 Seven Locks	Rd.		20817			USA	
	deat me	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of h	dispanic Origin? (	Specify Yes or No-	14. Race - Am Black, Wh	
õ	or ite	F	1 ☐ Never Married 2 ☐ Married	1⊠Yes 2□No		1 ☐ Yes 2 No		nto riican, etc.,	Specify: Wh	
ğ	urai',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates: WW L L					Specily. W11	100
<u>.</u>	"nat	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w	orking	16b. Kind of Busines	s/industry
7	within	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)	Jewe		u)		Jewelry	
2	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)		000		18. Mother's Na	ame (First, Middle, i		
an	ld be entel ked c	To Be	Benjamin Weiss				Rose	Weiss		
ary	shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Number	r, City or Town, State,	Zip Code)
Ž	alth a 27 is		Harriett Blankfel	d- Daughter	7710	Seven Lo	cks Rd.	Bethesda	, MD 20817	
Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or pher traumatic event, the Medical Examinar must be rediffied at once.		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location - City of	r Town, State
Ĕ	Pen In In In In In In In In In In In In In		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	T.	_	emorial		4-06	Olney, MD	
a	pertruit.		21. Signature of Funeral Fervice Licer	nsee	22	2. Name and Adel	zansky G	oldberg M	emorial Ch	napels, Inc.
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П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consec	Ineuce of.	nt.				
	LXamines	_	Sequentially list conditions, if any, leading to immediate	6. 05 too	ملالا	Jan :				
	ed sit	Examiner	rt any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	Juence of):	410	4 81 1	10 17 MOZ	1	
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760,	ete be executed hysiclen and the burial-transit	Cai	l l		,					1
∞ -	ficete g phy: ts the	edic		. d.						-
Box 6	nding use a	\$	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of d	elivery
	death certifice e attending ph ed for use as the	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c		∃Ectopic pregnanc ∃ Other (specify) _	у		Month	Day Year
P.O.	t the by the	Physician/Med	9 Unknown	9 Unknown						
	es tha gned se de	by P	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Ita	Attending Physician: The law requires that the rideath. sctor: Afler this certificate has been signed by the tuneral director, page 2 should be detach.	Be	25. Was case referred to medical examiner?					eath (Check only on	ne)	
Division of Vital	hysi this c	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	1	II 3L DOA			ence 6 Other (Sp	ecify)
ב	ling F	- Fo	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe ho	ow injury occurred	
Si	death death ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not b	B One Diese of Injury At h	ome farm et		]Yes 2 □No	28f Location (S	treet and Number or I	Pumi Poute Number
<u>&gt;</u>	efter Direct	Certification:	4 Homicide determined	building, etc. (Special	fy)	reet, ractory, office		City or Town		nurar noble Nurrber,
	To the Hospital or Attending Physician: The taw requires that the death certifice within 24 hours elter death.  Jo the Funerei Director: After this certificate has been signed by the attending phytother Funerei Director. After this certificate has been signed by the tending the completely illed in by the funeral director, page 2 should be detached for use as the completely illed in by the funeral director.		29a. Certifier Certifying Pt	ysician: To the best of my kno	owledge, deat	h occurred at the ti	me, date and place	ce, and due to the c	ause(s) and manner	as stated.
	Me Ho	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death oc	curred at the time, d	late and place, and di	ue to the cause(s)
	To the within To the Comple	ž	29b. Signature and title of certifier	/		29c. Licen	se number	2	9d. Date signed (Mo	nth. Day, Year)
)	5		MILLE	Karlin		DI	4753		8/23/	04
	_		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print) ROBEI	RT B. KR	OOPNICK,	MD	00 1
			40000010	CONS/15	200	1 200	16 200	1, 1, 1C	Merce M	M.1-719nD
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32. Segistrar's Sign	ature A	selv				

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 200	6 28757
	*		Decedent's Name (First, Middle, L.	.ast)				2. Date of Dea	ith	3. Time of Death
	Physici		Eric Tante	ly White				August	al 200	
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number	)	4b. City, Town, o	r Location of Deatl	-	4c. County of De	ath
			John Hopkin	ns Hospit	al	Balti				
	Funeral		Social Security Number     6.	.Sex 7. A 1(X) M 2□F	ge (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Aug. 18	y, Year) 9. B	irthplace (State or Foreign Country)
	Director		None	1 ga	Yrs.	3		Aug.18	,2006 Ma	ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary	ğ	MD Howar	·d	Elkrid	lge				1 ☐ Yes 2 X No
	within 72 hours after deeth with the Maryland ane. than "natural", or Items 23e or 28e-1 show is Modicel Examinar mast be notified at	Funeral Director	10e. Street and Number 5735 Rowanber	rv Drive	Apt. 210	10f. Zip Code 2 1 0 7	5		10g. Citizen of What (	Country?
	leeth ne 23	eral	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of F	lispanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
36	72 hours after dee "natural", or Items	by Fun	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates	? No	If Yes, specify Cubin	an, Mexican, Puert	o Rican, etc.)	Black, WI Specify: A	
21215-0036	tura stura	edi	15. Decedent's	Education	16a. Dece	edeni's Usual Occup	pation		16b. Kind of Busines	ss/industry
215	77 nin 72	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4o)	life.	e kind of work done DO NOT use retire	during most of wor d)	king		
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Maryland	end 2 should be filed withir eath and Mental Hyglene. n 27 is marked other than ser traumatic event, ILA M.		19a. Informant's Name/Relationship Dominique Rase	oloson/Mo	other 57	ing Address <i>(Street</i> 35 Rowan	and Number or Ru berry D	rai Route Numbe Prive, A	Rasolosoi or, City or Town, State ot. 210	lkridge, MD 21075
ē,	of Head		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City	
Ë	Pages nnt: # Its		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		° Fairfax	matory`or other pla Memoria ark	il Aug	0064,	Fairfax	, Virginia
Baltimore,	permit. Pages 1 end 2 should be Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Lice  Bean Little	m. Danie	1	2. Name and Addre Fairfax 9902 Br	ss of Facility Memori addock	al Fund Rd. F	eral Home	e A 22032
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Вох	eath certific ettending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of o	lelivery Day Year
	the e	sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4∐Pregnant 9□Unknown	at time of death 5	Other (specify) _				,
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of	Phy or this oral d	٦.	27. Manner of Death	28a. Date of In				1	low injury occurred	O <del>o</del> Cny)
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	To the Hospital or Attending Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical (	29a. Certifier 12 Certifying (Check only one) 2 Medical Ex	Physician: To the best saminer: On the basis and manner:	st of my knowledge, dea of examination and/or i stated.	ith occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	and due to the corred at the time,	cause(s) and manner dale and place, and d	as stated. ue to the cause(s)
	Fo thi	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
	->-0		> 800	L M.D.		RE	5-000	) 1	August 2	1 2006
	t		30. Name and address of person wh	no completed cause of	death (Item 23a) (Type	. Print)				
	Sta	ite	Sarah Skeite 31. Date filed (Month, Day, Year)	32- Pagis	North Wo		et balt	imore	MU ZIZ	5 /
	Regist		AUG 25	2006 Far	w St Sp	we				

State of Maryland / Department of Health and Mental Hygien 20628758 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 08 Alma **Physician** 35M 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs. 90 Director 214-03-1479 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examination to notified at 1X Yes 2 □ No MARYLAND WICOMICO WILLARDS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7446 CANAL ST. 21874 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or itan 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ۾ WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRESSER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM THOMAS DOWNS OLIVE BELLE BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Importent: if item 27 is any injury or other trau once. 36627 BI-STATE BLVD., DELMAR, DELAWARE 19940 ROBERT J. WILKINS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t XBuriat 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) NEW HOPE CEMETERY 8/26/06 WILLARDS, MARYLAND 21. Signatury of Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myocardial Physician disease or condition resulting in death) /Medical Examiner Longestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit -oronan Due to (or as a consequer ce of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ιį Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 20 No Vital within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 \_\_npatient 2 ER/Outpatient 3 DOA of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tunios 116 D56312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Berlin, MD 21811 33 Huway 32. Aggistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2006

DHMH 17 Rev 1/2001

Registrar

DOB 3/25/1916 Dr. 5/23/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:40 pM Victor Manuel Burneo Zambrano August 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Hours Min. 8. Date of Birth (Month, Day, Year)
OCT 1, 1985 Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1**X**M 2□ F Months Equador Director none 20 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 1 ☐ Yes 2 ☐ No Directo MD Rockville Montgomery 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code me 23a or 2 5801 Nicholson Lane, #223 20852 Equador by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after di Depertment of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or item any injury guother traumatic event, the Mudical Examination. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1

Yes 2□ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Equador Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Student High School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cesar Alfonso Burneo Dolores Matilde Zambrano 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother 5801 Nicholson La, #223, Rockville, MD 20852 Dolores M. Zambrano 20b. Place of Disposition (Name of cometery, crematory or other place of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/24/2006 Silver Spring, MD 21. Signature of Funeral Service Licensee Thibadeau Mortuary Service, P.A. 933 Gist Av, LL, Silver Spring, MD 20910 M00956 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERKALEMIA /Medical Examiner INTRACRANIAL HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit HYPERTENSION Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sete hes been signi page 2 should be ENDSTACE RENAL BISEASE 1 Yes 2 No 3 Probably 4 Unknown PIDERMULLYSIS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete 1 ☐ Yes 2. No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Tes After thi 28c. Injury at Work? 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural Injury 5 Pending efter death.

Director: Aft
in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completely filled in by I 4 | Homicide ö 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00057124 8122106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 9715 Medical Center Drive, #201, Rockville, MD 20850

Registrar DHMH 17 Rev 1/2001

State

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2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner P.O. Box 68760, Division of Vital Records,

**Physician** 

/Medical

Examiner

10a. State

Director

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Certification: To

Medical

29a. Certifier

attending physicien and for use as the burial-transit

cate has been signed by the page 2 should be detached

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 Department of Health ar Important: If item 27 is eny injury or other treat once.

this certificate ours after death.

leral Director: After this certific filled in by the funeral director. To the Hospitel of within 24 hours af To the Funeral D

> State Registrar

31. Date filed (Month, Day, Year) SEP 1 2 2006

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Jeff

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200628761 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year RAXITEL15 . N. 10 a. A M DREYROS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE harforo RO. 6108 OID If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 12 M 2 F Days Hours Min. 88 189-46-6777 Aug 30, 1918 GREECE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A

RO 6108 21214 hastord 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CARPENTER CORP NIA

MR GYROS UNKNOWN 11 Cholas olexene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALLOMA 212/4 ARGYROS wife 6108 Old harford BARBARA Rs.

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State H☐Burial 2 ☐ Cremation 3 ☐ Removal from State CARney 4 ☐ Donation 5 ☐ Other (Specify)

Demetrios Cem 22. Name and Address of Facility
PAUL STELLA FUNERAL Home, PA
7527 harferd RD. Balto. MD &1 21. Signature of Funeral Service Licensee Vaul

23a. Parts. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Imphom. Due to (or as a consequence of)

Due to (or as a consequence of)

14. Race - American Indian,

WhiTe

Approximate Interval Between Qnset and Death

/ Pu

Year

Day

Black, White, etc.

18. Mother's Name (First, Middle, Maiden Surname)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of)

IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Physician/Medical Part II. Other significant conditions contributing to death put not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Completed by

1 🗌 Yes

performed? Yes 2.2 No 1 ☐ Yes 2□ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and | lace, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nes 10 RX 31. Date filed (Month registrar's Signature 2006

State Registrar

**Funeral** 

Director

with the Maryland

ages 1 and 2 should be filed within 72 hours atter death with the Marylan nt of Health and Mental Hygiene.
It of Health and Mental Hygiene.
It litem 2.2 is marked other than "naturel; or items 23a or 28e-f show or other traumatic event, the Madical Examination matter mail teamorthind at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once.</u>

**Physician** 

/Medical

Examiner

been signed by the attending physicien and should be detached for use as the burial-transit

this certificate has rai director, page 2.

Be

Certification: To

To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director,

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

þ

Completed

Be

Examiner

17. Father's Name (First, Middle, Last)

				State of Ma		artment of H			giene		
		1	For State Registrar			ertificate of L			Reg. No.2 0	106	28762
Physi	cian		. Decedent's Name (First, Middle, L					2. Date of De Month	Day	Year	3. Time of Death 12:04 M
/Me	dical	ŀ	a. Facility Name (If not institution, gi	> VUW N		4b. City, Town, or	Location of Dea	8	29 4c. Count	2006 ty of Death	12.09
Exan	iner		University of MD		uma Cente	1 - ' ,	_		N	/A	
Funera	al		. Social Security Number 6.		e (In yrs. last birthda)		If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Count	· · · · · · · · · · · · · · · · · · ·
Directo	r	-	217-72-6300 Jsual Residence of Decedent	ILIM ZĀĻ	4.7 Yrs.			4-19	<b>-</b> 1959	MARY	LAND
ylend		-	Oa. State 10b. County		10c. City, Town or		3.4.			10	Od. Inside City Limits
e Mar	ctor		MD. N/A		BALTI			· · · ·	40 000	(115 - 1 0	1 X Yes 2 No
with the or 21	Director		0e. Street and Number	. n		10f. Zip Code			10g. Citizen of US		ury r
deeth me 23	Funeral	-	1003 BETHUNE I	12. Was Decedent	Ever in U.S. 13	/ 2122 I. Was Decedent of H If Yes, specify Cuba		Specify Yes or No		ace - America lack, White, e	
1215-0036 within 72 hours effer death with the Marylend ene. then "netural", or iteme 23e or 28e-f show the Madical Examinar must be notified at	I.E.		1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes 2  If Yes, Give		1 Tes, specify Cube	Specify:	no modil, etc.)		ify: BLAC	
21215-0036 ad within 72 hours ef vaiene. er then "neturel", or t, the Medical Exam	od be		3 ☐Widowed 4 ☐Divorced  15. Decedent's	Year or Dates:	16a. Dec	edent's sual Occup	ation		16b. Kind of		
215 hln 72 Men'n	Completed	-	(Specify only highest g	College (1-4or	(Gin	sedent's sual Occup re kind of work done of DO NOT use retired	during most of w d)	orking	EO	ΔD	
N DD.	S					CASHIER	19 Mothar's No	ame (First, Middle	FO		
land id be filed fentel Hyginked other ilic event,	8	5	17. Father's Name (First, Middle, La.  ANDREW BROWN					NE SHAW	s, <i>malour corre</i>	arrio,	
Maryland to 2 should be file the end Mentel Hy 27 Is marked oth treumetic event	F		19a. Informant's Name/Relationship	7.	19b. Ma	iling Andress (Street			er, City or Tow	m, State, Zip	Code)
- 0 1			TENNILLE (DAUG	HTER)	200 mm ( 5.1 km)	375 PENTWO	OOD RD.		1		
More, I Peges 1 end nent of Heelt int: If item 2 ury or other		1	20a. Method of Disposition 1 Burial 2 Cromation 3		cemetery, c	position (Name of rematory or other plac N CEMETERY	9-	Date 1-2006	20c. Location BALTT		MARY LAND
			4 □Donation 5 ☑ Other (Special Service Lice			- 1					
Balt permit. Depart Import	ä		) anth	. C). H	Bre	1721-27 N.	MONROE	ST. BAL	TIMORE,		
			23a. Part1. Enter the disease, or co shock, of heart failure. List on	ly one cause on each l	ne.				arrest,		Approximate Interval Between Onset and Death
Physicia /Medic			Immediate Cause (Final disease or condition resulting in death)	a Mul	a consequence of):	organ	failu	re			
Examin	_			b. Sep		•		$\alpha$			
E P #		5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	0 -1		(0)			
xecute and Il-trans	Evenine	1	that initiated events resulting in death) Last		a consequence of):	faucitis		-11/h	WL		
1760, Ite be executed sysicien and he burial-transit	1 -			d				V.			
68 iffice	Mod		IF FEMALE:	ODe House subserve	of				904.5	Date of delice	
Box leeth cert ettendin for use	Paylaciology Mad	Z Z	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	у			Date of delive Month	Day Year
P.O. that the ded by the deteched	974	2	9 🗆 Unknown	9□ Unknown				1			
dS, F	Ì	2	Part II. Other significant condition	s contributing to death I	out not resulting in the	e underlying cause giv	ven in Part I.		Tobacco use co ]Yes 2 X No		ne cause of death?
of Vital Records, Physician: The law requires to this certificate has been signed and director, page 2 should be a	Post of Care	1010						24a. Wa	s an 241	b. Were auto	psy findings available
Re(The tay te hes	.   8							per	opsy formed? 2 🔀 No	death?	mpletion of cause of 2 No
Vital Fidelian: The certificate	0	0	25. Was case referred to medical examiner?			i au		eath Check only	0 10		
Of V Physic this co	1	2	1 ✓ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpat		Heil 3D DOX		Home 5 Res			oject burned
ith. After	100	Certification,	1 □Natural 5 □ Pending 2 ☑ Accident investiga	Month, D.	y Year) Injur	y Wo	rk? ]Yes 2 No	leg wi	th haati	ng po	ad write
Division or Attending after death. Director: After	914		3 Suicide 6 Could no 4 Homicide determin	ZXA PIACE OF IT	jury - At home, farm, tc. (Specify)	/		City or T	own, State) In	03 Ret	hune Road.
pitel o	3		29a. Certifier 12 Certifying	Physician: To the bes		nonce	ime date and pla	BaHim	ore, MD	21273	
Division of Vital Re To the Hospitei or Attending Physician: The I within 24 hours after death. To the Funerat Director: After this certificate he completely illed in by the funeral director, page		Medical	(Check only 2 Medical Ex	aminer: On the basis and manner s	of examination and/o	r investigation, in my	opinion, death oc	curred at the time	date and plac	e, and due to	o the cause(s)
To the To the To the Company		Ž	29b. Signature and title of certifier	21.		29c. Licens			29d. Date sig	ned (Month,	Day, Year)
			30. Name and address of person w	Jam.	MD		S40 AN ZAHII	R	08/2	9/06	
2			POBOX 57	HUGHESI	ILLE,	4D 206					
	State	1.3	31. Date filed (Month, Day, Year)		rar's Signature	~ ~					
DHMH 17 Re	istra 1/200		SEP 12	2006	w H	Cooks					
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			For State Registrar	State of Marylan	d / Depart <i>Certit</i>	ment of F ficate of	lealth and Death		giene 200 ( Reg. No.	5 28763
17	Physicia	an	1. Decedent's Name (First, Middle, Las	t)		2	ROWN	2. Date of De Month	Day Yeer	3. Time of Death 8:55 PM
¥	/Medic	al	DONALD  4a. Facility Name (If not institution, give	atroct and aumber!	4		r Location of Deat	AUGUST	31 2006 4c. County of Dea	
	Examin Funeral Director	er	5. Social Security Number 6. S	Toplant Hos	Dital	G C C C C C C C C C C C C C C C C C C C	If Under 24 Hrs Hours Min.	8. Date of Bin	N/A	thplace (State or Foreign outly)
			216-34-1002 Susual Residence of Decedent		0 9			Dec 1	1550 1141	yrana
	how Let		10a. State 10b. County		y, Town or Locat	ion				10d. Inside City Limits
	e Ma Ba-f a	cto	Maryland Anne A	cundel	Annapol					1 TYYes 2 □ No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	eath v	erai	1792 B Belle Di	12. Was Decedent Ever in U.	S 13 Was	2140		Specify Ves or No	USA 14. Race - Amo	erican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funerai	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give X Year or Dates:		es, specify Cub	tispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)	Black, Whi	te, etc.
<u>۾</u>	72 hor	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a. Deceden	t's Usual Occup	nation	dkina	16b. Kind of Business	/Industry
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Maryland	i be fi	Be	17. Father's Name (First, Middle, Last) William A. Brow				Marie		Maiden Sumame)	
Ž	hould d Mer mark matic	ဥ	19a. Informant's Name/Relationship (		19h Mailing A	Address /Street			ar, City or Town, State,	Zin Code)
<b>∑</b>	ith an		Audrey Brown (W:		0				s, Md. 21	
ē,	f Hea f Hea ltsm		20a. Method of Disposition	20b. F	lace of Disposition			Date	20c. Location - City or	
Baltimore,	Page ient o nt: If ry or		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi	TIONIO VELITORIO I TE	morial			-06	Annapolis	s, Md.
ä	partm porta porta		21. Signature of Funeral Service Licer		22. N	ame and Addre	ss of Facility	c Morti	ary, P.A.	
m	90 1 4 8		Lavy G. 4	Rese MOS 8.	3 82	l West	St. An	napolis	Md. 214	101
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the deat one cause on each line.	h. Do not enter t	he mode of dyir	ng, such as cardia	c or respiratory a	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lympto	mA					Onset and Death  3 MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a conseq						a VCAO
	Examiner		Sequentially list conditions, if any, leading to immediate	b. CIRRH						2 YEARS
7	nsit	nine	Cause (Disease or injury	Dus to for as a conseq	derice or,					
	execunand altra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):			•		
68760,	icate be executed physician and the burial-transit	edical		. d. =						
										1/1
ŏ	n cer endir	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		topic pregnanc	,		23d. Date of de	
P.O. Box	Attending Physician: The law requires that the death certificate in redeath. Todash. setter: After this certificate has been signed by the ettending setter: After this certificate has been signed by the funeral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of d		ther (specify)_	,		Month	Day Year
<u>Ч</u>	hat the		9 ☐Unknown  Part II. Other significant conditions of	ontphuting to death but not res	ulting in the unde	rhing cause on	von in Part I	23e Did t	obacco use contribute t	o the cause of death?
ds,	signe d be d	d by	Tanti. Ottor organization	on the batter of the control of the	aning in the dride	mying oddso gir	on are are i.		res 2□No 3□P	
Š	v requ	Completed						24a. Was		
Re	he lav	dmo			-			autop	prior to death?	utopsy findings available completion of cause of
ā	ificate or. pa	e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o		s 2□ No
<u> </u>	ysicie s cert direct	ToB	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Ott			dence 6 □Other (Spe	ecify)
<u>6</u>	g Ph ter th	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui			now injury occurred	
<u>.</u>	endin ath. or: Af	atic	1 Natural 5 Pending investigation	1	(6.1)		Yes 2 □ No			
Division of Vital Records,	i or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif		, factory, office		28f. Location (: City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death or tion and/or inves	ocurred at the til tigation, in my o	me, date and place	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon.	th, Day, Year)
	/		NAESS	MO		RE	5-000		august, 31,	2006
•	6		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Prii	nt)				
			NEIL AGGARWAL	,600 NORTH WOL	FE STREE	T, JUHNS	iteAkINS H	SPHAL, B	ALTIMORE, M	aryland 21287
6.4	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	The state of				-

		•	1- State Amend #7	State of Manylans	Certif	ment of He ficate of D	ealth and M Death	ental Hygie	ene 2006	28764
	Dharini		1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		MARTHA EUZ	ABETH BOD	SE			sept. 16	1,2000	2:35 AM
	Examir	er	4a. Facility Name (If not institution, give s ST. AGNES HO	SPITAL		BAUT	Location of Death	5	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex A/6-98-6362	7. Age (In yrs. la 84		f Under 1 Year lonths Days	Hours Min.	8. Date of Birth (Month, Day, Y 12-19-	(ear) 9. Birth	hplace (State or Foreign untry)
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Heelth and Mental Hygiene. Item 27 ie marked other than "naturel; or iteme 23a or 28a-1 show other traumatic event, the Musical Exeminer man be notified at	tor	10a. State 10b. County		Town or Locate	ion m onl	)			10d. Inside City Limits  1. ✓ Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	eth w		70.0077	GleN Road	_	2122	9		US	)
	item item	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑No	i. 13. Was	s Decedent of His es, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Bfack, White	
1215-0036	ours aff	à	3 Widowed 4 Divorced	Il Yes, Give Year or Dates:	10	Yes 21 No	Specify:		Specify:	Black
15-(	n 72 h	lete	15. Decedent's Edu (Specify only highest grade	cation a completed)	(Give kin	t's Usual Occupa d of work done do NOT use retired)	uring most of worki		b. Kind of Business/	Industry
212	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the M	Completed	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	4 3	me n				
	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)	In all works	nol	2017.0	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	should and Men marke umatic	ဥ	19a. Informant's Nam Pelationship (Ty	Be. Print)	19b. Mailing A	Address (Street a	nd Number or Rura	I Route Number.	City of Town, State, 2	Zip Code) 212.17
Ma	t and 2 s Heelth ar em 27 ie ther trau		George L 1	300e	2201	+ Moreni	It Royal	Terrane	0 01	none Md
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	COL	ace of Disposition	on (Name of one or other place		ate 20	c. Location - City or	Town, State
ij	permit. Pages Department of I Importent: if it eny injury or o		4 □Donation 5 □ Other (Specify)	Bali	timou i	Nations	119-1	8-06	Saltimo	
Bal	Departr Departr Importe eny inje		21. Signature of Funeral Service License	euthelos	Fu	ame and Address	SOT FACILITY P	PIA 2	431 E OL	veret, Belline
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.		1	g, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
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NA	and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	ate be executed thysicien and the burial-transit	dicai E		i	·					
9	artificating phy	Medi	IF FEMALE:							
Вох	that the death certifica ed by the ettending pt detached for use as t	cian/	23b. Was decedent pregnant in the past 12 pronths?	3c. ff yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of deal	death 3⊟Ec	topic pregnancy ther (specify)			23d. Date of del Month	ivery Day Year
P.O.	t the d	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown						
Division of Vital Records, F	8 P 9	Completed by Physician/Me	Part II. Other significant conditions con	ntributing to death but not resul	Iting in the unde	orlying cause give	n in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
eco		piete						24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
a R	sician: The law certificete hes t irector, page 2 s							performe	death? No 1 ☐ Yes	2□ No
Z.	Physician: rthis certifice ral director, p	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2×4	R/Outpatient	3□ DOA Othe		Check only one	ce 6 ☐ Other (Spe	ciful
οľ	g Phy ler this leral d	n: To	27. Manner of Death	- Ly	28b. Time of Injury	28c. Injury Work		28d. Describe how		ony)
sior	eath. or: Aft	catio	1 SNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Say 1 sar)	,		res 2□No			
Divis	i or Att efter d Direct d in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street )	, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number.
	To the Hospital or Attending Physwithin 24 hours effer death. To the Funerel Director: After this completely filled in by the funeral director.	Medical C	29a. Certifier Certifying Phyone) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati and manner stated.	on and/or inves	tigation in my on	inion death occurr	ed at the time data	e and place, and due	to the cause(s)
_	vithin somple	Med	29b. Signature and title of certifier	and married stated.		29c. License	number	290	d. Date signed (Mont	h. Day, Year)
	- > - 0		1	Meghan Checkley	MD I	BC99	16795		9/10/	06
	Ve		30. Name and address of person who or meghan the ckley	and manner stated.  Meghan Checkles  pempleted cause of death (ftem  900 Ca to  32 degistrar's Signate	23a) (Type, Pri	nt) Dept	of Emug	ing Med	ick, Ba	elimore) 21229
	Sta		31. Date filed (Month, Day, Year)	32 degistrar's Signati	ure /_	1.				
	Regist	rar	SEP 1 2 200	10 pleaser to	in fall the	34				

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** JAMES BARNETT 7,2006 SEPT 1:50A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA Maris HOSPICE-dulaney TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) APR. 7, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F 217 24 2609 76 Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 N. LINWOOD AVENUE 21224 Iteme 23a USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S.
Acced Forces?
1 Payes 2 □ No
1 Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ō ARMY 1 ☐ Yes 2 ☐ No Specify BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 9TH TRUCKING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fit f Health and Mental H Item 27 is marked ot JAMES BARNETT SR. RACHEL JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Health a ant: If Item 27 is 419 N. LINWOOD AVE. BALTO, MD. ce of Disposition (Name of Date 20c. Location (Name of GERALDNAY BARNETT (wife) 21224 other 20a. Method of Disposition 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny Injury or soce. □ Donation 5 □ Other (Specify) SEPT.13,2006 BALTO,MD. MT.ZION CEM. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. 21213 fmmediate Cause (Finaf disease or condition resulting in death) Physician **HUMAN IMMUNODEFICIENCY VIRUS** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No HOSPICE this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 143725 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2006 32. Registrar's Signature Registrar 4084P

SEPTEMBER

P.O. Box 68760,

Records,

Division of Vital

JAMES BARNETT

1242 Hillcreek Road  Pasadena  Funeral Director  5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 Months Days Hours  1 Usual Residence of Decedent	2. Date of Dea Month Septemb	Day Year	3. Time of Death						
Medical Examiner   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Pasadena   1242 Hillcreek Road   Pasadena   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 2   Months   Days   Hours   Days   Days   Days   Days   Days   Days   Days   Days   Days   Da		or 7 2006	3:05 A M						
1242 Hillcreek Road  Funeral Director  1242 Hillcreek Road  Funeral Director  1242 Hillcreek Road  Funeral Director  1242 Hillcreek Road  6. Sex 1 Age (In yrs. last birthday) 1 Months Days Hours  Hours  1 Months Days Hours	Desident								
Funeral Director  5. Social Security Number  216-74-5905  6. Sex 1 Months Days Hours  1 M 2 X F 47  1 Months Days Hours		4c. County of Death Anne Arun							
Director 216-74-5905 47 Yrs.	Min (Month, Day	(Year)   Cou	nplece (State or Foreign						
Usual Residence of Decedent	Nov. 1	6,1958 Ma	rýland						
10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Maryland Anne Arundel Pasader	na		1 Tyes 2% No						
109. Street and Number 109. Street and Number 1242 Hillcreek Road 21122	1	10g. Citizen of What Cou	•						
1242 HITICREEK ROAD 21122	rin? (Specify Yes or No-	United Sta							
Maryland Anne Arundel Pasader    10e. Street and Number   10f. Zip Code	Puerto Rican, etc.)								
See 3 Widowed 4 Divorced Specify:		Specify:	White						
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Elementary/Secondary (0-12)  College (1-4or 5+)  2 Years  Sales		Total Plas	stics						
To see the second of the secon	's Name (First, Middle,								
Prank Brodka		illard	i- 0 - 4-1						
The state of the s			21122						
20a. Method of Disposition 20b. Place of Disposition (Name of cametary, crematory or other place)		20c. Location - City or 1	Town, State						
1 □ Burial 2x □ Cremation 3 □ Removal from State □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	9/9/2006	Towson, Mai	cyland						
To be designed by the control of the	al Home of	Dundalk, In arvland 21	nc. .222						
23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
Immediate Cause (Final disease or condition resulting in death)  (Modical Cause (Final disease or condition resulting in death)			Onset and Death						
/Medical resulting in death)  Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):									
f any, leading to immediate of the control of the c									
resulting in death) Last  Due to (or as a consequence of):  d									
uticate be as the burn as the burn as the burn burn as the burn as									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1		23d. Date of deli							
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Diseas		Month	Day Year						
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The law require page 2 should 1	24a. Was a autops	an 24b. Were aut	topsy findings available ompletion of cause of						
Com Page	perfor	med? death? 2☑No 1☐Yes	2□ No						
26. Place of the symmetry of t	of Death (Check only or								
To spilar: 1 Inpatient 2 ER/Outpatient 3 DOA Orner: 4 Nur.  27. Manner of Death 28a. Date of Injury (Month, Day Yeer) Injury Work?	rsing Home 5 Aesid	ow injury occurred	nty)						
Logical State   State	40		:						
To see the control of	28f. Location (S City or Tow	itreet and Number or Ru n, State)	ral Route Number,						
29a. Certifier    Continue   Continue   Certifying Physician: To the best of my knowledge, death occurred at the time, date and continue   Cont	d place, and due to the c th occurred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)						
4 c d d d d d d d d d d d d d d d d d d	à	29d. Date signed (Month	, Dey, Year)						
	854	0/8/20	06						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 Balt.	more 2120	2						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar  SED 1 9 2006									

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Mary Vincenta Balsamo September 10, 2006 6:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-26-5874 1 □ M 2 🕱 F 76 Yrs. Director 21 1930 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "neturel", or Items 23e or 28a-f show other treumetic event, If a Madical Examiner must be notified at Directo Maryland Carrol1 Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 720 Changing Seasons Road 21157 United States of America death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3

Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph John Culotta Mary Fertitta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If item 27 Is eny injury or other tret. <u>once</u>. Joanne Newman (Daughter) 720 Changing Seasons Road, Westminster, MD. 21157 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slate Lake View Memorial Pk 09/14/06 Sykesville, Md. 21784 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilitiaring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licenses 8728 Liberty Road, Randallstown, Maryland 21133 Hemmino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as the burial-transit oranar g/g resulting in death) Last Due to (or as a consequence of attending physician Box 68760 certificate be ian/Medicai IF FEMALE use 23c, If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Physici 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed live 2 1 2 1 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Mann Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatur# and title of certifier 29d, Date signed (Month, Day, Year) 039J82 des nd address of person who completed cause of death (Item 23a) (Type, Print) East transweet westunder on MD tooain 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28768

			1 - State Registrar		Ce	rtificate of L	Death	Re	eg. No.	2010
	DI :		1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		3. Time of Death
	Physici /Medi		Herbert			Brya	nt	09	05 2006	2:50a M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			4607 Embassey	Circle #1	.04		s Mills		Balti	
	Funeral Director		353-22-44/0	ex 7. Age X⊓M 2□F	76 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01 15	9. Birt <i>Co</i>	hplace (State or Foreign untry) IL
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Manyl f sho	0	MD Balti	more	Ow <b>i</b> r	ngs Mill	c c			1 □ Yes v □ No
	286 100	Tec.	10e. Street and Number		0 11 21	10f. Zip Code		11	0g. Citizen of What Co	••
	3a or		4607 Embassey	Circle #1	04	21	117		U.S.A	
	me 2	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi If Yes, specify Cubar		pecify Yes or No-	14. Race - Ame	rican Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23e or 28e-f show event. The Medical Eventral must be rotified at	by	1 Never Married	1 XYes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2X No	Specify:	o Hican, etc.)	Specify:	a, etc. B <b>l</b> ack
2-0	72 ho	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occupa	ition	king	16b. Kind of Business/	Industry
2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	·)	kind of work done d DO NOT use retired,	)	\mu_g		
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last)				Mary J	ne (First, Middle, M	Maiden Sumame)	
2	should ind Men imarke	T <sub>o</sub>	Charles Bryant							
Ma	d2sh hand 7 ls r traun	1/ 3	19a. Informant's Name/Relationship (	ype, Pnntj	19b. Maili	ng Address (Street a				<sup>(ip Code)</sup> 21117
	iit. Pages 1 and 2 should ortment of Health and Men ortant: If item 27 is marke injury or other traumatic		Estelle Bryant	-Wife	20b. Place of Dispo	Embassi sition (Name of	ey Circ	le #104	Owings	Mills, M Town, State
Baltimore,	Pages nent of B ant: If ite ury or of		1 NBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other place	9)			
₹	permit. Pag Department Important: I any injury o		* 4 ☐ Donation 5 ☐ Other (Specify 21 Signature of Funeral Service Licery			n Forest 2. Name and Addres		/12/06_0	owings Mi	lls, Md
B	permit. Pag Department Important: I any njury o		/ Demold (	The state of	I I	larch F/I	H West	v 1 0 2		22.22.5
5	1 34 7		23a. Parl 1. Enter the disease, or com-	plications that caused					more, Md	21215 Approximate
P		Ш	23a. Pa 1. Enter the disease, or com strick, or heart failure. List only Immobiate Cause (Final	one cause of each line	· 15TM	MVA	Ann			Interval Between Onset and Death
	Physician /Medical		dise se or condition re ulting in death)	a. 11 C	016	MYOC	MAG	1pth 1	NFARC	(10 N
	Examiner			Due to (or as a	consequence of):	NALY	ART	EDY	DISEA	00
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):	04111		•		
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ó	exec an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):					
68760,	icate be executed physician and s the burial-transit	edical		d						
9	= 0 m	Med	IF FEMALE:							
Вох	attending for use	Iclan/I	23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy ! □ Fetal death 3 [	Ectopic pregnancy			23d. Date of deli	
	at the dea by the at tached fo	SC	in the past 12 months?  1  Yes 2 No	4□Pregnant at ti 9□Unknown	ime of death 5[	Other (specify)			Month	Day Year
<u>О</u> .	The law requires that the death case has been signed by the attendate 2 should be detached for us	Physi	9 Unknown		and and later to the			on- Didah		
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oro	w require been si should b	ted						1  Ye	s 2No 3∏Pro	bbably 4 🗍 Unknown
Records,	e law has b	Completed						24a. Was ar autopsy	y prior to c	topsy findings available ompletion of cause of
<u> </u>		So						perform	death? No 1 ☐ Yes	2 🗆 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Heenital		011		th (Check only one	9)	
of	Phye this al dii	2	1 Yes 2 No	Hospital: 1 ☐ Inpatien			4   Nursing Ho		nce 6 Other (Spec	rify)
n C		lo	27. Manner of Death  11 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	?	28d. Describe ho	w injury occurred	
Division	i or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be		y - At home, farm, st		'es 2□No	20f Location (Cts	mot and Number of Bu	ent Boute Mumbos
<u>&gt;</u>	or A after Direction by	ertif	4 Homicide determined	building, etc.	(Specify)	eet, ractory, onice		City or Town,	reet and Number or Ru. , State)	rar Houte Number,
	s Hospitel or Attending 24 hours after death. e Funerel Director: After letely filled in by the fune		29a. Certifier ↑ Certifying Ph	veicien: To the hest of	my knowledge deat	h accurred at the time	o date and place	and due to the on	uso(s) and manner as	etatod
	24 hos Fun etely	edical	(Check only 2 Medical Exemone)	ysicien: To the best of niner: On the basis of and manner state		vestigation, in my op	inion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To the Hospitel or within 24 hours after or To the Funerel Director completely filled in	Me	29b. Signature and title of certifier	1		29c. License	number	29	d. Date signed (Month	, Day, Year)
	- s - ŏ		> Renewor	han.	- Ma	Do	063	145	9/7/1	6
	111		30. Name and address of person who	completed cause of dea	ath (Item 23a) /Tyne	Print)		0	0	~
	511		ARVIND DE	= SA1 1	15 R	ESIA	ER R	D 40	LEN BO	BNIEM
	Sta	te	31. Date filed (Month, Day, Year)	32. Pigistrar	's Signature	Engal s				/ /
	Registr	1.0	CED 1 9 2	While Callet	15° 15	Contract of the same				

		1 - For Stata Registrar  1. Decedent's Name (First, Middle, Lasi	State of Ma	-	epartme Certifica			Mental Hy	Reg. No.	200		2876 S
Physici /Medio Examir	cal	MARY RUTH B  4a. Facility Name (If not institution, give	SSETT		4b. Cit	, Town, or	Location of De	SEPTEM	BER Day	9, 20 County of E	106	3:40 A M
Funeral	161	Saint Joseph 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birth		er 1 Year	If Under 24 H	son	th V Year)	9	Birthplac	more ce (State or Foreign
Director		238-26-1348 10  Usual Residence of Decedent  10a. State 10b. County	⊒м 2 <b>Х</b> Д F	84 Y		Days	Hours M	sept.	6,719	922 N		h Carolin
72 hours after death with the Maryland 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow Idical Examiner must be notilled at	rector	MD B	altimore		Park	vill			10g. Citiz	zen of Wha		1 ☐ Yes 2 No
death with	Funeral Director	8800 Old Harfor	12. Was Decedent Ev	_	13. Was Dec	212		(Specify Yes or No	)-	USA 14. Race - /		
72 hours after natural, or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ ∰ Vidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:	ento Hican, etc.)		Specify:	White etc Vhit	.e 
	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		()	ecedent's Us Give kind of w ife. DO NOT ashie	rork done d use retired)	tion uring most of v	working		nd of Busin rocer		•
a 1 and 2 should be filed within the file and Mental bygiene. Item 27 le marked other than other traumatic event, the M	To Be Co	10 17. Father's Name (First, Middle, Last) Ernest Lee S	Sink	1				Name (First, Middle e Ruth			ael	
ind 2 shou alth and M 27 le mar ir traumat	-	19a. Informant's Name/Relationship (7) James Bissett,		19b. 1	Mailing Addre	SS (Street a	nd Number or ds Cou	Rural Route Numb urt-Park	er, City or Vil	Town, Sta	te, Zip C	234
vermit. Pages 1 ar Department of Hea mportant: If item any Injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Commetery, Evans Chapel	Fune	otherplace <b>ra</b> I	9	-12-06		cation - City est		
permit. Departr Importr eny Inj.		21. Signatora of Funeral Service Licens	15 Fadd			Har	ford F	EVANS CH Road-Par	kvi.			
Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aSEVERE	CHRON	C 089			liac or respiratory a		ISEA	lr C	pproximate nterval Between Inset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	consequence of							+	
ate be executed sysician and he burial-transit	cal Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of	:							
es that the death certificating the death certificating the death certificating by the attending phy be detached for use as the	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (				2	23d. Date of Month		ay Year
requires that the signed by hould be detailed	5	Part II. Other significant conditions co	_	not resulting in t	he underlying	cause give	n in Part I.					cause of death?
The law ate has b	Completed							1 Tes	osy ormed? 21X No	prior	to comp	y findings available letion of cause of
G 5 4	tion: To Be	25. Was case relerred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Naturat 5 Pending investigation	Hospital: 1 Minpatien 28a. Date of Injury (Month, Day	28b. Tir	ne of	28c. Injury Work	4 Nursing	g Home 5 Resi	dence 6		Specify)	
al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, street, lacto	ry, office		28l. Location ( City or To			r Rural F	Rou <i>te Number,</i>
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsicien: To the best of iner: On the basis of e and manner state	examination and/	death occurre or investigation	d at the tim on, in my op	e, date and pla inion, death o	ace, and due to the courred at the time,	cause(s) date and	and manne place, and	or as state due to th	ed. ne cause(s)
To the Youthout To the complet	Σ	29b. Signature and title of certifier	2.55		2	9c. License			29d. Date	e signed (M	LO	
10		30. Name and address of person who o	M.D. 7	601 OS	, , , ,	RIVE	TOWSO	N MARYL	AND	212	204	
Sta Regist		31. Date filed (Month, Day, Year) SEP 1 2	32. Registrar	's Signature	Loon	20						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, 2006 4:44 PM M **Physician** Patricia Ruth Bitzel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

68 Yrs Months Days Hours Min. Date of Birth Month Day Year) 03/23/1938 Birthplace (State or Foreign MO Country) 5. Social Security Number **Funeral** 1□M 200F 494-42-4616 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD Baltimore Parkville 1 Yes 2 No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1813 Wentworth Road 21234 USA death ' Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Pages 1 and 2 should be William J. Guest Helen Henson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any Injury or other trau Daniel Bitzel/Husband 1813 Wentworth Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep 13 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup>Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year P.O. I 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not/resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 🗌 No 3 Probably 4 Unknown been unlue 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 11, 2006 wo 8 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) Charles St. Balto. Md 212dy GBINC 6701 Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

For Amend #5&8 Per State Cooks any language the state Registrer

For Amend #5&8 Per State Cooks any language the state of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert Bonds 11:44AM 09 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore SAINT BALTIMORE AUNES HOSPITA1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Aug 78 | 1921 5. Social Security Number 4 7. Age (In yrs. last birthday) Birthplace (State or Foreign No. Carolina **Funeral** 1 □XM 2 □ F 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at **Baltimore** 1 ☐ Yes 2 ☐ No Maryland N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or U.S.A. 417 Gwynn Avenue 21229 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry American Standard Radiator Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pagas 1 and 2 should be fill thant of Haalth and Mantal H tant; if item 27 is marked other Annie Bonds George Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Gwynn Avenue Baltimore, Maryland 21229 Mary Bonds Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department or Important; if any njury or once. ö 09/15/06 Glen Burnie, Md. Glen Haven Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Licens 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 onot enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** 1WFFH. /Medical Due to (or as a consequence of): Examiner COLLAPSE. Lung RIGHT MAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) cartificata has been signed by tha ractor, paga 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🗆 No 4 Unknown 1 Tes 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: funaral diractor, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 2010 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient Certification: To 3 DOA this 27. Mann f Death Date of Injury (Month, Day Year) 28b. Time of Aftar t 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury after daath. 1 ☐ Yes 2 ☐ No 2 Accident investigation tha e 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) complately filled in by 4 🗌 Homicide within 24 hours a To the Funeral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-18613-M-13-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - CATON AVE. BATIMBRE, MD-2129. SAM, MUHAMMAD 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BONDS, ROBERT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Charlotte Freda Compher Crawford Be11 September 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 926 9. Birthplace (State or Foreign Days Hours Months 577 30 1038 A 1 □ M 2 🕶 F Mary land 80 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director Mryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1706 Rollings Avenue 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Item any injury or other treumetic event, the Medical Exemination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's County Elementary/Secondary (0-12) College (1-4or 5+) Math Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Charles Compher Charlotte Correlle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raleigh Bell (Husband) 1706 Rollins Avenue Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) September 13°Cc. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 2006 Addison Chapel Cem. Chapel Cem. 2000 Capitol Heights, MD
22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria FerryRoad Clinton, MD 20735 Inches 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dificile Colitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician s the burial IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Day Month Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Urin 1 Yes 2 No 3 Probably 4 MyUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 💢 No To the Hospital or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 ☑ No Medical Certification; To 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \ Homicide within 24 hours a To the Funeral C completely filled i filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Sept 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MO AnneArund HOWARD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 6:30 PM M 2006 Julia Ann Carman September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/11/1931 Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Hours Min 75 032-22-3627 NY **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MO Harford Directo Abingdon 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21009 20 Box Hill Parkway #221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Southeastern Guide other then Elementary/Secondary (0-12) College (1-4or 5+) Accountant Dogs permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 te marked oth any july or other treumatic event 2002: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cyrus C Stow Mary Louise Poque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Linda Wagner/Daughter 1004 Milchling Dr. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Chesapeake Crematory 9-12-06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives de 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): Examiner months 15 chiemic cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner o the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 1 ☐ Yes 2 00 1 ☐ Yes 2 ☐ No : After this certifical funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) VIOSPICE ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Salatural 2 Accident 5 Pending reral Director: A investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

6565

32. Registrar's Signature

Gordan

2 2006 29c. License number

D0051926

N. Charles St. Baltymore du 21204

29d. Date signed (Month, Day, Year)

			For State Registrar	State of I	Marylar	•	artmen				lental Hygi	ene g. No. 20	06	287	171
			Decedent's Name (First, Middle, La	st)							2. Date of Death	1		3. Time of De	
	Physici /Medio		JUANA LUCIA	CLAROS	3						Septembe		06 ear	11:26	ρМ
1	Examir	ner	4a. Facility Name (If not institution, giv		er)		4b. City,	Town, or	Location o	of Death		4c. County of	Death		
			6006 36th Avenu		Ann Harris	In a black of the	Hya If Under		ille	24 Um 1		Prince			
	Funeral Director		5. Social Security Number 6. S 220-11-3971	ex □M 2፟A F /.	86	last birthday) Yrs.	Months		If Under : Hours	Min.	8. Date of Birth (Month, Day,			ce (State or Fo	oreign
			Usual Residence of Decedent		00				1		12/13/19	919 E	II Sa	<u>lvador</u>	
	nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				<u> </u>		100	d. Inside City L	imits
	Ba-f s	cto	·	George's	Ну	yattsvi	.11e							1 X Yes 2 [	] No
	or 2	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of Wh	at Countr	y?	
	s 23e	ra	6006 36th Avenu					2078				U.S.A.			
	item item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 [Yes 2]	157	13. \	Was Deced f Yes, spec	ent of History of Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	14. Race - Black,	American White, et		
036	urs af		3 Midowed 4 Divorced	If Yes, Give Year or Date			X Yes 2	2□ No	Specify:			Specify:			
Ö Q	within 72 hours after death with the Maryland ene. than "nature!, or items 23a or 28a-f ahow he Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation		16a. Deced				-4 -41	1	6b. Kind of Busi	ness/Indu	stry	
2	ithin 79.	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	kind of wor DO NOT us	e retired)	uring most )	or workii	ng				
7	ygier ygier her th	Cor	4			Homema	aker	7				Own Ho			
and	be fi	Be	17. Father's Name (First, Middle, Last)								(First, Middle, M	•			
ž	hould d Mei mark matic	P L	Samuel Chavaril  19a. Informant's Name/Relationship (			105 14-11-		(0)			Gutierr				
Maryland 21215-0036	d 2 s Ith an 27 is trau		Soledad Santizo		r	6006									
ē,	tem (		20a. Method of Disposition	Daugnee	20b. F	Place of Dispo	sition (Nam	e of			sville,	Mary Lan  Oc. Location - Ci			
ê	Pages ent of ht: if i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		10	zemetery, cren zland Na			· 1	lant	14, 2006	Tauro	1 M	a mr. 1 am	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!", or items 23a or 28a-f show any injury or other treumatic event, the Macitial Examiner must be notified at ance.		21. Signature of Funeral Service Con		2 3372.3	22	. Name and	d Address	s of Facility	Gas	ch's Fun	eral Ho	me.	ary⊥and P.A.	1
ď	Depa Impo any i		Anhut 1	Man							, Hyatts		MD 20	0781	
			23a. Rart1. Enter the disease, or com- shock, or heart failure. List only	olications that caus	ed the deat	h. Do not ente	er the mode	ol dying	, such as	cardiac o	r respiratory arres	st,	A	opproximate	en.
	Physician		Immediate Cause (Final disease or condition	//		Dement:								Inset and Dea	
	/Medical Examiner		resulting in death)	/a. /	as a conseq										
	Examiner		Sequentially list conditions,	b											
	Sit B	lhe	Sequentially list conditions, if any, leading to intriediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	ue ice of).									
V	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):									
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E				, .									
<b>68</b> 7	ificate g phy as the	edic		, d											
Box	n cert anding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna							23d. Date of	ol delivery		
m.	deatl	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	at time of d		Ectopic pre Other (spe					Month	D.	ay Year	
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s,	res that the death certific igned by the attending p be detached for use as	þ	Part II. Other significant conditions of		but not res	ulting in the un	iderlying ca	iuse give	n in Part I.		23e. Did toba	icco use contribi	ute to the	cause of deat	1?
ord	w require	ted	Congestive heart								1 🗆 Yes	2 ☑ No 3	☐ Probab	ly 4 ∏Unki	10 <b>W</b> f1
ec	law las b	Completed	Atrial fibrillat:	Lon							24a. Was an autopsy	24b. We	re autops	y findings avai	labie
<u> </u>	: The	ပ္ပ									performe	ed? dea	ith?	□No	
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Division of Vital Records,	Phys this ral dir	<u>۲</u>	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 ☐ Inpa 28a. Date of Ir		ER/Outpatient 28b. Time of			4 LI NUI		ne 51K Residen		(Specify)		
o	ding h. After fune	盲	1 ☑Natural 5 ☐ Pending	(Month, L	Day Year)	Injury	M	Bc. Injury Work'	ai ? es 2 □ N		8d. Describe how	mjury occurred			
/ISI	Attending Physicism: r death. sctor: After this certific by the funeral director.	flca	3 ☐ Suicide 6 ☐ Could not be		Injury - At ho	ome, larm, stre					8f. Location (Stre	et and Number	or Rural F	Route Number	
á	al or after	Certification;	4 Homicide	building,	etc. (Specif	v)	,,				City or Town,	State)		1001011001	
	pspit hours uners y fille		29a. Certifier 1⊠ Certifying Ph	ysician: To the be	st of my kno	wledge, death	occurred a	t the time	e, date and	place, a	nd due to the cau	ise(s) and mann	er as state	=====================================	
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	edical	one) 2 Medical Exam	and manner	of examina	tion and/or inv	estigation,	ın my opi	inion, deatl	n occurre	d at the time, date	e and place, and	due to th	e cause(s)	
	With To I	Σ	29b. Signature and title of certifier		1	1		License		A		d. Date signed (A			
,			· wyne	aus	10	U	1	1-10	940	10		7-11-	-06		
	17		30. Name and address of person who	empleted cause of	death (Item	1 23a) (Type, F	Print)	1.	10-1	14.	Blvd.	< 11.			41
	Sta	to.	31. Date filed (Month, Day, Year)	32 Planis	Q 10 strar's Signa	1 27	7 4	MIV	C131	TYI	DIVA -	1. 1Ve1	1	11.19,	MA.
	Registr			006	Elden .	J. Sa	and I			•				-	

State of Maryland / Department of Health and Mental Hygiene 28775 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** KING CARR September 9, 2006 8:40 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Life Care Mitchellville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1⊠M 2□F Months Hours 368-22-3535 84 Director June 8, 1922 Michigan Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahov ed other than "natural", or items 23s or 28s-f ahove event, the Modical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Prince George's Maryland Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road #C-455 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1⊠Yes 2⊡No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Yes, Give δ 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Science Analyst Federal Government permit. Pages 1 and 2 should be filed Department of Health and Mentat Hygic Important: if Itam 27 is marked other any injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roswell G. Carr Edith L. Bigelow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine S. Carr - Wife 10450 Lottsford Road #C-455, Mitchellville, MD 2072 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 09/11/2006 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service tricensee 9000 2011 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part). Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only exause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Diabetes Mellitus: Type 2 Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): the burialphysicien Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Post Polio Syndrome; Anemia Chronic Disease 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 No 1 ☐ Yes 2 🖾 No 1 Tes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No Certification: To 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 1 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25079 09/11/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Don Yablonowitz 7404 Executive Place, #502, Lanham, Maryland 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

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			1 - For State Registrar	State	OI IVIA	liylail		rtificate			u Wentarri	Reg. N	2006	28776
			Decedent's Name (First, Midd	le, Last)							2. Date of D Month	eath	ay Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution	-	number)					Location of D	eath		c. County of Dea	ath
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	and w		Usual Residence of Decedent  10a, State 10b, County	,		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Manyla fed a	tor	Maryland Harfo			-	ingdon							1 ☐ Yes 2 ☑ No
	n 28a	Directo	10e. Street and Number	JLG		AU.	nigaon	10f. Zip	Code			10g. C	itizen of What C	Country?
	23a c	rai D	2905 Preston 1	ane					21009				SA	
	er dez	Funeral	11. Marital Status 1 □ Never Married 2 2 3 Ma		Forces?		S. 13. Y	Was Deced If Yes, spec	dent of His cify Cubar	panic Origin n, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Am Black, Wh	
3	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow Jical Expoller out be notified at	by	3 Widowed 4 Divorce	. If Yes,	s 2 <b>)</b> N Give Dates:	10		1 ☐ Yes	2€ No	Specify:			Specify:	White
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Maryland 2	e filed within Hygiene. other than	Be Co	8 17. Father's Name (First, Middle	, Last)			Homem	aker		18. Mother's	Name (First, Middle		n Home n Sumame)	
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ar <sub>2</sub>	2 should and Men is marke aumatic		19a. Informant's Name/Relation	ship (Type, Print)			19b. Mailir	ng Address	(Street a	n <b>d Numbe</b> r o	r Rural Route Num	ber, City	or Town, State,	Zip Code)
	s 1 and of Health item 27 other tr		Otho Lee Cool	/ Husba	nd	20h P	2905	Pres	ton :	Lane,	Abingdon,	Man	ryland 2	
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г			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause o	it caused n each lir	the death	Do not ent	er the mod	le of dying	such as car	diac or respiratory	arrest,	2	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Ò	vel	um	10/4	gell	4				years
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	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	$\mathcal{C}$	O'U	nou	y an	te	y C	Klobar	e		
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289	B 44			d										
ROX	eath certific attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, 1 ☐ Liv		of pregna 2  Fetal		Ectopic pr	regnancy				23d. Date of de	
О. П	ne dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		agnant at known	time of de		Other (sp					Month	Day Year
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rds	w requires been sign should be	ed by									_ 10	Yes :	2 <b>)</b>	Probably 4 Unknown
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Vital Records,		Con									per 1 Tes	2 N	death?	s 2 No
<u> </u>	ryaician: Th	Be C	25. Was case referred to medic examiner?	Hospital:			ER/Outpatier		Othe	r	Death (Check only		0 TO# /0-	
O	ding Phy. h. After this funeral d	n: To	27. Manner of Death	28a. Da	te of Injui	v	28b. Time of		8c. Injury Work	at	ng Home 5 Res 28d. Describe			вспу)
300	ttendin death. tor: Aft the fur	atio	2 - 7100100111	tigation		7,0417	Injury	М		es 2 □No				
Division	I or Attendi after death. Director: A	Certification:		mined 289. Pi	ace of Injui	ry - At ho c. (Specify	me, farm, str	eet, factory	y, office		28f. Location City or To			Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certify	ing Physician: To	the best (	of my know	wledge, deatl	h occurred	at the tim	e, date and p	lace, and due to the	a cause(	s) and manner a	as stated.
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medica one)	I Examiner: On the and m	a basis of anner sta	examinat ited.	ion and/or in	vestigation	, in my op	inion, death o	occurred at the time	, date ar	nd place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of pertific	er 	7			290	. License	number	<b>-</b>	29d. D	ate signed (Mor	nth, Day, Year)
•	1		20 Name and address of	who completed c	)	eath Ata-	23a\ /T	Deint)	<b>U</b>	111			1 2 10	4
	10		CHOUS	ECV	- 7	U	C)m	20	1 W	1-8621	cotta	M	£,	المحاد حرما
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	Registi	ar	SEP 1 2	5 4000 1 8	State of	20 6	K Lie	MEAST B	y					

			eartment of Health and Mertificate of Death	ental Hygier	7111b /8///
	sician edical				3. Time of Death 6 2006 19:54
3	miner		4b. City, Town, or Location of Death SILVER SPRING  If Under 1 Year If Under 24 Hrs.	8 Date of Birth	tc. County of Death  MONTGOMERY  9. Birthplace (State or Foreign
Direct	or	215-14-9686	Months Days Hours Min.	(Month, Day, Yea 08/21/1	908 N. CAROLINA  10d. Inside City Limits
ith the Mary or 28a-f sh	Director	10e. Street and Number	MARLBORO  10f. Zip Code	10g. (	XXYes 2 ☐ No Citizen of What Country?
ore, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinating to institling at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Vas, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036 d within 72 hours at giene. sr than "natural", or the Wed cal Ex. III	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  3RD  16a. Dec (Giv life. CUS	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired) TODIAN	B;	 Kind of Business/Industry ALTIMORE CITY UBLIC SCHOOLS
laryland 212' 2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Man	To Be (	17. Father's Name (First, Middle, Last)  ROBERT RAWLS	WINNIE	(First, Middle, Maide RAWLS	
'e, Mar 1 and 2 sh Health and tem 27 is m		20a. Method of Disposition 20b. Place of Disp	OS SUTHERLAND CR	, UPPER	MARBORO, MD Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe	œi .	1 X Bunal 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)  Cemetery, cre ARBUTU	B MEM. PK. 9/13	/06 B	ALTIMORE CO., MD WERAL HOME 21207
n Fore	OUCE	23a. If the chief the disease, or complications that caused the death to not en	1600 LIBERTY HEI	GHTS AV,	BALTIMORE, MD  Approximate Interval Between
Physicia /Medic Examine	al	Immediate Jause (Final disease of condition resulting in death)  PNEUMONIA  a			Onset and Death WEEK
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
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T.O. BOX 6  at the death certific by the attending I	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 XNo 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.O. law requires that the as been signed by th 2 should be detache	þ	DEMENTIA	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
The ate h	e Completed	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
n of ng Phys	To B	25. Was case referred to medical examiner?  1   Yes   2X   No			6 □Other (Specify) ury occurred
5 g # g 5	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
the Hospital hin 24 hours a the Funeral I	Medical	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	vestigation, in my opinion, death occurre	d at the time, date ar	nd place, and due to the cause(s)
con Viet	2	29b. Signature and title of certifier  ACULCU  CO.	29c. License number D 1 9 6 0 9.	29d. D	ate signed (Month, Day, Year)
4	State	30 Name and ddr. If erson who completed se of death (Item 23a) (Type UII) S 10 S 10 S 10 S 10 S 10 S 10 S 10 S 1	In Rd. #202,	GANHO	Sburgh, MD
Regi		CED 1 2 2006 American de la	and I		

			For State Registrar	State	of Mary	yland / Dep <i>Ce</i>	artment of ertificate of		id Menta		ene . 2 (	06	28778	8
	Physicia /Medic		1. Decedent's Name (First, Middle	Mary A	nn Da	neker			Mon	of Death	Day 2006	Year	3. Time of Death	
	Examin	er	4a. Facility Name (If not institution Gilchrist Hosp	•	umber)		Tow	·	Death		4c. County	ltimo	re Co.	
P	Funeral Director		5. Social Security Number 216-12-2824	6. Sex 1 □ M <b>XX</b> F	7. Age (II	n yrs. last birthday Yrs.	If Under 1 Year   Months   Day		Min. (Mor	of Birth nth, Day, Y		Coun	lace (State or Foreign try) yland	_
1	f show	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         E	altimore		Oc. City, Town or L	ocation		E	dgeme	ere	1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No	
4	3a or 28a	I Director	10e. Street and Number 2717 Wells Av	70			10f. Zip Code	21219	9		D. Citizen of V		•	_
0000	is a rand, should be filed whill if a hous area loads with into the waysand that had Mahalal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr  3 Widowed  Divorced	12. Was De	Forces? 2 ⊠ No Sive	er in U.S. 13.	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	Hispanic Origin ban, Mexican, P			14. Rac	e - Americ ck, White,	an Indian,	
יייין אַר	ne. han "natura Medical E	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	st grade completed	f) (1-4or 5+)	(Giv.	edent's Usual Occ e kind of work don DO NOT use reti	e during most of ed)	f working		Sb. Kind of Bu	usiness/Ind	dustry	
שוום ל	ntal Hygie ed other t	Be	8 Years 17. Father's Name (First, Middle, Andrew Barcza				Mail Cle		Name (First, I	Middle, Ma		10)	Service	_
Mary	Ith and Me 27 is mark traumation	L L	19a. Informant's Name/Relations  Joseph Daneker	hip (Type, Print)			ling Address (Stre			Number, (	City or Town,			_
nore,	permit. Fages I am Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition  1 Description  4 Donation 5 Description	3 □Removal from	n State	20b. Place of Disp cemetery, cre St. Stan	ematory`or other p	/ace)	Date	20	c. Location -		wn, State Maryland	_
	Departm Importar any injur		21. Signature of Funeral Service		(ei	D.	22. Name and Add uda – Ruck 7922 Wise	ress of Facility Funeral	l Home	of Du	ındalk	, Inc		_
í.	hysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that only one cause or	t caused the each line.		nter the mode of d		rdiac or respira			(	Approximate Interval Between Onset and Death	
E	certificate has been signed by the attending physician and Borector, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	De o (or as a c	(finsequence of):  onsequence of):  onsequence of):	tea '						yean	_
O. DOX 0	the attending the check the control of the check to the check the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 (gnant at time	Fetal death 3	□Ectopic pregnar				23d. Da Mo	te of delive	ory Day Year	
ecords, P.	quires man n signed by uld be deta	ρ	Part II. Other significant condition  At al fibr	ons contributing to	death but r	not resulting in the	underlying cause	given in Part I.	1	e. Did toba			ne cause of death?	
I Heco	ine iaw re ete has bee page 2 sho	Completed			•				_	a. Was an autopsy performe Yes 2	ed2	prior to con death?	psy findings available impletion of cause of	
N	certific ector,	Be	25. Was case referred to medical examiner?	Hospital				\thor	f Death (Check				16	_
0 10	To the repetite of Attending Prysicials. The far within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investi	28a. Dat	Inpatient te of Injury onth, Day Y	28b. Time	of 28c. In	4 🗆 (4013)			ce 6 10th	er (Specif red	Hospice	
Division	s after des	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 289. Pla	ce of Injury Iding, etc. (	- At home, farm, s (Specify)	street, factory, office	ө		eation (Stre or Town,		er or Rura	l Route Number,	
:	the Hospi nin 24 hour the Funer pletely fills	edical	(Check only 2 Medical one)			camination and/or i	nvestigation, in m	opinion, death		e time, dat	e and place,	and due to	the cause(s)	
)	With Con	Σ	29b. Signature and title of certifie	2	ly.	mo	02	nse number		5	d. Date signe		Day, Year) 7, 2006	
į	6		30. Name and address of person	who completed ca	use of dear	th (Item 23a) (Type	Print) St.	Balto.	md 21	1205	٤			_
	Sta Regista		31. Date filed (Month, Day, Year) SFP 1 2 2	006	Hegistrar's	Signature	4. Share							

		For State Registrar	State of Maryla	and / Depa <i>Cer</i>	irtment of He <i>tificate of D</i>	ealth and M D <i>eath</i>		giene2001	6 28779
6 390	Č.	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
Physicia /Medic	al	Louis	Overt	on	Dani			BER 09, 20	006 8:40 A M
Examin	er	4a. Facility Name (If not institution, give st		PM.	4b. City, Town, or L	POINT		4c, County of De	eath
Funeral		VA MARYLAND HEALT  5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9.8	inthplace (State or Foreign
Director		23 <b>7-</b> 16-6742	M 2□F 85	Yrs.	Months Days	Hours Min.	05 19	21	NC NC
and *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits
Maryla 1 aho	lor	MD NA		•	dsor Mi	11			1 XYes 2 No
n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
23a c		8303 Charmel Dr	ive		2124			U.S.	
er des Iteme	Funeral	TI, Waltar States	2. Was Decedent Ever in Armed Forces?	10.S. 13. V	Vas Decedent of His I Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecrfy Yes or No Rican, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, hite, etc.
irs aft	by F	1 Never Married 2 Married  Muldowed 4 Divorced	1 Nes 2 No If Yes, Give Year or Dates:	1	I□Yes 2₹No	Specify:		Specify:	Black
within 72 hours after death with the Maryland ene. Than "natural", or iteme 23a or 28a-1 ahow the Madical Examiliner must be motified at	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupat	tion uring most of work	ina	16b. Kind of Busines	ss/Industry
vithin ne. hen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)			Salf Emp	Loved
Hygie Hygie ther ti	e Co	3rd Grade  17. Father's Name (First, Middle, Last)	na	Ca	rpenter	18. Mother's Nam		Self Emp	Toyea
id be ental ked o ic ave	To Be	Charles Daniel				Pearl B			
shou and M mar umat	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin				er, City or Town, State	, Zip Code)
and 2 ealth and 27 i		Bilal Hassan-So							, Md 21244
ges 1 t of Ha if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		sition (Name of natory or other place	l l	Date	20c. Location - City	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. To bours after a feet 21 as marked other than "natural; or iteme 21 as native of any injury or other traumatic avent, its Markleal Examinar must be confided at once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License			norial Pa		1/06	Randalls	town, Md
Departimpo impo any i		Humi	K K.k		Name and Address		Bal+i	more, Md	21215
		23a. Part1. Enter the disease, or complic shock, or heart fature. List only on	ations that caused the de	eath. Do not ente	er the mode of dying.	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CEREBRAL V						Onset and Death UNKNOWN
/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
* * *	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
cuted	Examiner	that initiated events							
sate be executed obysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
icate be executed physician and sthe burial-transit	edicai	d.							
		IF FEMALE: 23 23b. Was decedent pregnant	c. If yes, outcome of pre-					23d. Date of c	delivery
The law requires that the death cert lite has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)		-	Month	Day Year
that the de ed by the a	Phys	9 Unknown				i D. Al	22a Did to		to the server of death?
ires It signer d be d	d by	Part II. Other significant conditions cont DEMENTIA	mouting to death but not	resulting in the ur	nderlying cause giver	n in Pan I.			to the cause of death?  Probably 4 XUnknown
w requir been si should	ietec						24a. Was	an 24h Were	autopsy findings available
The lav	Completed						autop perfo	osy prior t rmed? death	o completion of cause of
	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes		65 2 110
hysician: this certific	To	1 ☐ Yes 2 ☐ XNo	ospital: 1 Inpatient 2					dence 6 Other (S	pecify)
ding Ph h. After th tuneral	ion;	27. Manner of Death  1 Matural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work	at ? es 2 □No	28d. Describe h	now injury occurred	
Attender death rector:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	t home, farm, stre		63 2 110		Street and Number or	Rural Route Number,
pital or purs after leral Dire	Certification;	4  Homicide determined	building, etc. (Spe	əcify)			City or Tov	vn, State)	
To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certifier (Check only one)	ician: To the best of my left: On the basis of exame and manner stated.	knowledge, death ination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		-	29c. License	number		29d. Date signed (Mo	onth, Day, Year)
		1 16h CL	1	· · · · · · · · · · · · · · · · · · ·	D52739	)		SEPTEMBER	09, 2006
17		30. Name and address of person who con				a avamer.	DEDEST	DOTNIE NE	21002
Sta	te	SURESH SHANDELYA M 31. Date filed (Month, Baye Year)	1.D., VA MAR 32. Registrar's Si		LALTH CARE	· PXPTEM	PERKY	FOINT, MD.	. 21902
Registr	-	SEP 1 2 20			bash				

		•	1 - For State Registrar	State of	Maryland		artment <i>tificate</i>			ind M		giene Reg. No.	2006	28780
B	Physici /Medio		1. Decedent's Name (First, Middle, Last) Elizabeth F. Daly								2. Date of De Month Septemb	Day	, 2006	3. Time of Death 2:50 P M
	Examin		4a. Facility Name (If not institution, give s 2924 Baltimore Ave	2.			Lansd	lowne				Ва	County of Death	
	Funeral Director		5. Social Security Number 216-32-1888 6. Sec	M 2 12 F	7. Age (In yrs. I. 70	a <i>st Dirthday)</i> Yrs.	If Under Months	Days	If Under 2 Hours		8. Date of Bir Month Da Ct 26,	193	5 Mary	nplace (State or Foreign Land
	Maryland I-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimore			, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28s	Director	10e. Street and Number		Dans	downe	10f. Zip					10g. Citiz	zen of What Cou	untry?
	na 23e	Funeral	2924 Baltimore Ave		dent Ever in U.	S. 13. V	2122 Was Deced	ent of His	spanic Orio	gin? (Spe	cify Yes or No	U.S.	A. 4. Race - Amer	ican Indian,
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow if Item 27 is marked other, the Macilcal Examinat must be inclined at or other treumatic event, the Macilcal Examinat must be inclined at	by	1 □ Nøver Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed For 1 Tes If Yes, Give Year or Da	2 🔀 No e	'	fYes, <i>s</i> pec 1□Yes 2	ify Cubar	Specify:	, Puerto F	Rican, etc.)		Black, White Specify: wh:	
Baltimore, Maryland 21215-0036	ithin 72 ho ne. "natui Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		-4or 5+)	life. I	kind of wor DO NOT us	k done d e retired)	urina most	of workin	g	16b. Kir	nd of Business/I	ndustry
g 7	filed w Hygier ther th	Col	17. Father's Name (First, Middle, Last)		.	Home	Maker		18. Mother	r's Name	(First, Middle		Home	
<u>lan</u>	Aental Aental rked o	To Be	Ernest E. English								hausen		,	
lary	2 should and Men is marke		19a. Informant's Name/Relationship (Ty			The second		(Street a	nd Numbe	r or Rural	Route Numb		Town, State, Z	ip Code)
	1 and Health iem 27		Kevin Daly, Sr./So	n	20b. P1	of Di	sistem /hlam			n.	rsvill		0 7	own, Slate
Ē	Peges nent of i int: if it	1	Burial 2 Cremation 3 R	emoval from S	Mari Cem	etery cren Vland etery	Veter Cro	her piace an wnsv	" ille	9-13	-2006	Cros	vnsvill	e Maryland
Balti	permit. Pege Department of Important: if eny injury or once.		21. Signature of Funeral Service Lice S	bar	100	W 22	. Name and	d Addres	s of Facility	Ambr	ose Fu	neral	L Home o	of Lansdowne
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	aDue to (	aused the death ach line.  Or as a consequence as a conse	dev ience of):	er the mode	e of dying	, such as o	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	dical Examiner	Cause Disease or injury that initiated events resulting in death) Last		or as a consequ	ience of):								
O. Box 6	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1☐Live bi	come of pregnal rth 2  Fetal ant at time of de wn	death 3	Ectopic pre Other (spe					2	3d. Date of delik Month	very Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	itributing to de	alh but not resu	Ilting in the u	nderlying ca	ause give	n in Part I.		1	2		the cause of death?
il Records,		Completed								· · · · · · · · · · · · · · · · · · ·	24a. Was autoj perfo 1 Yes		24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
Zi Si	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:				.   Othe	r		(Check only o			
Division of Vital	Attending Physician: The in deeth.  ector: After this certificate he by the funeral director, page	atlon: To	27. Manner of Death    Natural   5   Pending     Accident   investigation		npatient 2 1 of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗆 Nui		8d. Describ <i>e</i> l		Other (Spec	ify)
Divis	or At	Certification;	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location ( City or To			ral Route Number,
	To the Hospital or At within 24 hours efter or To the Funeral Directompletely filled in by	edical	29a. Certifying Physical Check only one)  Check only 2 Medical Examination	sician: To the ner: On the ba and mann	isis of examinat	wledge, death ion and/or in	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the id at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	withi To t	Ň	29b. Signature and title of certifier	A	of 1	410	29c	License	number	(1)		29d. Date	signed (Month	Day, Year)
	¥.		30. Name and address of person who co	inple ed causi	e of death ( em	7	7	86	01 1	Yet	evans	1 ++	NAT N	S+ 111
	Sta Registr		31. Date filed (Month, Day, Year) \$EP 1 2 2	32. R	gistrar's Signal	ture!	parie	)	IVILL	IEV	2011	17	IVED	21100

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artmer rtifica	nt of H te of L	ealth ar D <i>eath</i>	nd Me	ntal Hyg	giene Reg. No.	2006	28	3781
	Physici		1. Decedent's Name (First, Middle,	Last)	Lic						Date of Dea Month	ath Day			of Death
	/Medic Examin		4a. Facility Name (If not institution, of NORTHWEST	HOSPITAL		JER (ast birthday)	If Unde	L ND	Location of I	Death OW Hrs. 8	Date of Birt	4c. BA	County of Dea	th	COUNTY te or Foreign
	Director		230-30-5108 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	79	Yrs.	Months	Days	Hours	Min.	(88717	/192	27 VA	untry)	
	anyland show	Ļ	10a. State 10b. County			, Town or Lo									City Limits
	28a-f	recto	MD Baltin  10e. Street and Number	ore	Gwy	nn Oak		Code Code				10g. Citi	zen of What Co		65 2/2/10
	23a or	rai Di	3809 Arbutus Ave				21	207	,			USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow any fujury or other traumatic event, the Medical Examinar must be multiped at DDGs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 1 Yes, Give Year or Dates:			Was Dece f Yes, spe 1 ☐ Yes	cify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify: <b>Bla</b>	e, etc.	,
2-0	"natur	ieted	15. Decedent's (Specify only highest			16a. Deced	dent's Usu kind of wi	ork done d	lurina most o	f working			nd of Business tinghou		
21215-0036	d withir giene.	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5		Engin		150 7011700	,						
Maryland	uld be file Mental Hy irked other itic event.	To Be C	17. Father's Name (First, Middle, La Alexander Dixon						18. Mother's Minni		First, Middle, leman	Maiden	Sumame)		
Man	aith and 2 sho		19a. Informant's Name/Relationship Beverly Dixon/Wit										Town, State, 2 21207	Zip Code)	
Baltimore,	Pages 1 a ment of Hei ant: If Item ury or othe		20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		a	lace of Dispo emetery, cren esapea	natory or	other plac		Date Se ac. 20	p 15		cation - City or		
Balt	permit. Departi Import any inj pace.		21. Signature of Funeral Service Lie	other Mo	1443	3 8	717 0	reen	s of Facility ind Fun Pastur	es Dr	ive B	alti	es more, Ma	ryland	1 21286-
	Crate be executed  Physician and physicien and physician transit the purial-transit	dicai Examiner	23a. Part. Enter the disease, or composition or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. ATHEROS  Due to (or as  c. Due to (or as  d	a consequence a consequence	uence of):	CAR	DIAL	I	NFA	PCTIC	N SEA	+5€	Approxi Interval Onset a	nate Between nd Death
Division of Vital Records, P.O. Box 6	The law requires that the death certific tte ras been signed by the ettending p baye 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	]Ectopic p ] Other (s					2	23d. Date of de Month	ivery Day	Year
rds, P.	w requires that t been signed by should be deta	ρ	Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	nderlying	cause give	on in Part I.			obacco u 'es 2[	se contribute to		of death?
II Reco	The law requ	Completed								_	24a. Was autop perfor 1 Yes		death?	utopsy findir completion	gs available of cause of
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:		ER/ utpatien		Othe			Check only n				
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the tuneral director, page		1 Yes 2 No  27. Manner of Leath  1 Natural 5 Pending 2 Accident investiga	28a. Oate of Inju (Month, Day	ry	28b. Time of Injury		28c. Injury Work	4 🗆 Nursi	280	5 ∐ Hesid		Other (Spe y occurred	cify)	
Divis	s effer death s effer death bl Director: ed in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho	me, farm, str	eet, factor	y, office		28f	Location (S City or Tow		d Number or Ri	ural Route M	lumber,
	To the Mospital or within 24 hours after To the Funeral Dir. completely filled in I	edicai (	29a. Certifier (Check only one) Certifying Certifying	Physician: To the best aminer: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred vestigation	at the time, in my or	e, date and p pinion, death	place, and occurred	d due to the d at the time, d	cause(s) date and	and manner as place, and due	s stated. to the caus	se(s)
)	To t To t	X	29b. Signature and title of certifier	1	/ 1	ND ON	29	c. License	number 8933	3			T 8, 2		r)
	4		30. Name and address of person with KER ITA JOSE	2. 6 1 . 2			Print)	RT	DL	JOAL	Grow	12 / 1	15 UN	(32	
	∦ Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	-		A STATE OF THE STA		100	711	_ ,	.71			

			For State Registrar	State of M	arylan	id / Depa <i>Cei</i>	artmei <i>tifica</i>	nt of He te of D	ealth a Death				1e <sub>10</sub> .2 (	006	28782
П	Physicia		Decedent's Name (First, Middle, La.	st)							2. Date of Month		Day	Year	3. Time of Death
	/Medic		Albert Anthon					T.S. VIII			Septe			2006 ity of Death	20:34 "
}	Examin	er	4a. Facility Name (If not institution, give					, Town, or l		Death		'	ec. Coun	ity of Death	
			Union Memoria  5. Social Security Number 6. S			last birthday)		rimore	If Under 2	4 Hrs.	8. Date of	Birth		9. Birthpl	ace (State or Foreign
	Funeral Director			FIM 2DF	6	Yrs.	Months	Days	Hours	Min.		Day, Yea			ylvania
			Usual Residence of Decedent								rune	1-74			
	nylan how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	Od. Inside City Limits
	Ba-1 s	cto	Maryland Harford	1	Al	berdeer	1,			_					1 ☐ Yes 2 No
	or 24	Dire	10e. Street and Number					p Code				10g. (	Citizen o	of What Coun	try?
	ath w	ra	748 Mahan Road			0 140		1001	0.1	:-2 /0			SA	ace - Americ	an Indian
	er de Item	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces 1 Ves 2	?	.5. 13.	f Yes, sp	edent of His ecity Cuban	, Mexican	, Puerto F	Rican, etc.	NO-		lack, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	140		1 🗌 Yes	2 <b>⊋</b> No	Specify:				Spec	city: Whi	+0
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. sd other than "natural", or items 23a or 28a-f show event, I're Modical Exertirett and ke notified at	pa	15. Decedent's E			16a. Dece	dent's Us	ual Occupat	tion			16b.	Kind of	Business/Inc	
215	- 20	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	life.	Rind of W DO NOT	ork done di use retired)	uring most	or workin	g				
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	al Hygi I othar vant, I	Be (	17. Father's Name (First, Middle, Last	)					18. Mothe	r's Name	(First, Mic	idle, Maid	en Sum	ame)	
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Maryland	2 2 2		19a. Informant's Name/Relationship (											vn, State, Zip	Code)
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altimore,	ges 1 al t of Hea If itam or otha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	•   '	cemetery, crei	natory or	other place		<del>-18</del>	-06			5301 P1 8617	
ţ	t. Pa tmen tant: njury		*4 □ Donation 5 □ Other (Special		Hi.	lltop :	Serv:	.ce Co	orp  -	9-16	-06-	To	wson	, Mary	land
Bal	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service Lice	marsh	nn	AL I	COm:	nd Address Is Fur Okesk	neral	Home Rd.	Abin	A gdon	, Ma	ryland	21009
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the deal	th. Do not en	er the mo	de of dying	, such as	cardiac or	respirato	ry arrest,			Approximate Interval Between Onset and Death
	Physician	£ 17	Immediate Cause (Final disease or condition	m	1000	rdia	1, 1	n fan	ctic	0					Onset and Death
	/Medical		resulting in death)	Due to (or a											
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	pe #s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a		erche		1 1		\ -					10000
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60,	icate be executed physician and s the burial-transit			545 15 (6. 4	0 4 0000	4001100 0171									
38760,	phys phys the	edicai		_ d											
4			IF FEMALE:	23c. If yes, outcom	e of pregn	ancy							23d. I	Date of delive	ery
Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2   Feta	al death 3[	Ectopic Other (	pregnancy specify)						Month	Day Year
o.	at the de by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	anni										
۵.	res that igned b	by Pt	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	inderlying	cause give	n in Part I.		23e. [	oid tobacc	co use co	ontribute to th	e cause of death?
rds	quires n sign										1	☐ Yes	2 🗌 No	3 ☐ Prob	abiy 4 Minknown
Vital Records,	s been si	Completed										Vas an	24	b. Were auto	psy findings available mpletion of cause of
Re	The lav	E O			_						1 D Y	iutopsy erformed es 2 <b>2</b>		death?	•
ital		a	25. Was case referred to medical						26. Place	of Death	(Check o	<u>.</u>			
$\leq$	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ∰No	Hospital: 1   Inpa	tient 2	(ER/Outpatie	nt 3 🗆 l	Othe Othe	r: 4□Nu	rsing Hon	ne 5□f	Residence	6 🗆 0	Other (Specif	y)
1 of			27. Manner of Death  1	28a. Date of In (Month, D	jury Jay Year)	28b. Time o	of	28c. Injury Work	at	2	8d. Descr	ibe how i	njury occ	curred	
ior	Attanding r death. ector: After by the fune	atic	2 Accident investigation	n			М		/es 2 □	No					
Division	N or Attand after death   Director: ,	tific	3 Suicide 6 Could not to determined	280. Place of I	njury - At h etc. <i>(Spec</i> i		reet, fact	ory, office		2		on (Stree Town, S		mber or Rura	I Route Number,
	ital or A rs after ral Directled in by	Certification:		<u> </u>											
	To tha Hospital within 24 hours a To the Funaral completely filled	Medical	(Check only 2 Medical Exe	hysicien: To the bes miner: On the basis	of examin	owledge, deal ation and/or in	th occurre vestigati	d at the tim on, in my op	ie, date an pinio <i>n</i> , dea	d place, a th occurre	and due to ed at the ti	the cause me, date	e(s) and and plac	manner as s e, and due to	tated. the cause(s)
	tha thin 2 the mplet	Med	29b. Signature and title of certifier	and manner	stated.		2	9c. License	number			29d.	Date sig	ned (Month,	Day, Year)
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	ntl		" Theatell	UUKU2	111	J 225) (T =	Deine)	000	108	10		Je	DIE	· IVET II	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	104		30. Name and address of person who Eli's a bett			m 23a) (Type	Print)	e 15.d	e Pa	· Kw	625	Sito	A	Belean	1,2006 np.mo
	C+	ate	31. Date filed (Month, Day, Year)	32. Radis	trar's Sign	pature and	The Trans								
	Regist		SED 1 9	2006	Garage a	16 1	1030	ES							

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 28783 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 10, 2006 Margaret W. Dittenhofer 10:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance House Silver Spring Montgomery 8. Date of Birth (Month, Day, Y 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🛛 F Days Hours Mary Tand 78 215-26-3325 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location if fem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Modical Ever it ar must be inclined at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8122 Gracefield Road 20904 Apt. 306 United States by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, if a Medical Exercity and page. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant/Auditor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Windsor Viola Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mortimer A. Ditterhofer/husband 8122 Gracefield Road Apt. 306, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 12. 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgamery Crematorium 2006 Bethesda, Maryland 21. Signature of Funeral Service Licens Robert A. A. Princhirely Funeral Home, Bethesda-Chevy Chase, Inc. Millian a. Tumphres 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiinfarct dementia /Medical Due to (or as a consequence of) **Examiner** Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Parkinson's disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Tes 2 🗌 No 1 Yes To the Hospital or Attanding Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a filled 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59524 over September 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31.10 Gracefield Road, Silver Spring, Maryland 20904 Loveen Puthumana, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2006 Registrar

		1 - For State of Maryland / Dep State of Maryland / Ce	artment of Health and M rtificate of Death	lental Hygien	e2006 28784
Physic		1. Decedent's Name (First, Middle, Last)  Catherine Elizabeth Evans		2. Date of Death Month September	ay Year 5:58 PM
/Medi Exami		4a. Facility Name (If not institution, give street and number) Carroll Lutheran Village	4b. City, Town, or Location of Death Westminster	4	c. County of Death Carroll
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 216-36-7556 1 M 20 F 92 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 10/19/1913	9. Birthplace (State or Foreign Country) Maryland
Maryland f show	tor	Usual Residence of Decedent  10a State 10b. County 10c. City, Town or L  MD Carroll County Westm	ocation inster		10d. Inside City Limits 1 ☐ Yes 2 ÅNo
with the la or 28a I be notii	Directo	10e. Street and Number 200 St. Luke Circle	10f. Zip Code 21158	10g. C	Citizen of What Country? USA
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-1 show aumatic event, Ite Marked Examble in the Indified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Nover Married 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d 2 should be filed within 72 hours af the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, ile Model Exwent	Completed t	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Makar	ing	Kind of Business/Industry  HOME
e d la b	To Be Cor	17. Father's Name (First, Middle, Last)  A.P. Spindler		e (First, Middle, Maide	
5 € Z		Mary Fries/daughter	ing Address (Street and Number or Rui 283 Lake Dr. Nokom	al Route Number, City	v or Town, State, Zip Code)  275  Location - City or Town, State
permit. Pages 1 ar Department of Hea Important: If item sany injury or other once.		1 Burial 2 □ Cremation 3 □ Removal from State Loudon F	emalory or other place) Park Cemetery 9-11	-2006 Bat	limore, Maryland
permi Depar Impo			22. Name and Address of Facility Amb 1328 Sulphur Sprir	ng Rd. Arbu	
Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (offas a consequence of):	Prouvemen		Interval Between Onset and Death
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death certific e attending p id for use as	by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
juires that t n signed by uld be detat		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
The tay ate has page 2	Completed			24a. Was an autopsy performed?	
To the Hospital or Attending Physician: Th within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1  Accident investigation	ent 3 DOA Other: 4 hursing H	th (Check only one) ome 5 Residence 28d. Describe how in	
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To the within To the complex c	×	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
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			For State Registrar	State of I	Maryland		artmen tificate			nd M		giene Reg. No.	2006	28785
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	Physici /Medic		Carroll								Septeml	per 9		11:55 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		er)		, ,	Town, or L Balti				4c. C	ounty of Death N/A	
	Forest		Future Care Irvin  5. Social Security Number 6. Seg	x 7.	Age (In yrs. la	ast birthdav)	If Under		If Under 2		8. Date of Birt	h		place (State or Foreign
	Funeral Director		212-22-5233	XM 2□ F	78		Months	Days	Hours	Min.	MAR 4,	1928	Cou	yland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 City	. Town or Lo								10d Inside City Limite
	laryla show	ŏ			Toc. City									10d. Inside City Limits 1    Yes 2   No
	the A	Director	Maryland N/A  10e. Street and Number			Вал	Ltimoi 10f. Zip			-		10a. Citize	en of Whal Cou	
	3a or		2111 Ashburton Sti	reet					216				USA	,
	death	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S	S. 13. \	Was Deced	ent of Hist	panic Origi	in? (Spe	cify Yes or No- Rican, etc.)	. 14	. Race - Ameri	
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Maryland 21215-0036	al Hyg	Bec	17. Falher's Name (First, Middle, Last)					1	8. Mother	's Name	(First, Middle,	Maiden S	umame)	
yla	Duld b Ment arked atlc	5	Charles David Edv								na Jord			
Nar	12 sh h and 7 le m reum		19a. Informant's Name/Relationship (Ty Arthur Edwards, S									-	Town, State, Zij	
	1 end Healt em 2		20a. Method of Disposition	5011	20b. Pl	ace of Dispo	sition (Nan	ne of			Saltimo		Maryland	
ο̈́	ages ant of it: If it		1 ☐ Burial 2 🎇 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ite ce	emetery, cren	natory or o	ther place)	1	00/11	1.706			
Baltimore,	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", or itema 23a or 28a-f show eny injury or other treumatic event. Ite Medical Examinar must be motified at once.	Ī	21. Signature of Funeral Service Licens		Met	22	Name an Cremat	d Address Lion	of Facility SOC16	ety (	L/06 Of Mary	land,	Inc.	Maryland nd 21228
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Division of Vital Records, P.O. Box	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 2 ☐ Fetal tat time of de	death 3	Ectopic pro Other (sp					23	d. Date of deliv Month	ery Day Year
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<u>, io</u>	death. ctor: Alt	atio	1 Matural 5 ☐ Pending investigation	(Worth)	Day 7 Gui)	тірту	М		s 2 N	lo				
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	To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)	sician: To the be ner: On the basi and manner	s of examinati	wledge, death ion and/or in	occurred vestigation,	at the time in my opir	, date and nion, death	place, a	nd due to the o	ause(s) a date and p	nd manner as s lace, and due t	stated, o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	pitys		~~~~	290	License i		-/>			signed (Month,	
•	M		30. Name and address of person who co	ompleted cause of		23a) (Type,	Print)					-		1, 2006
			21 Date filed (Morth Day Year)		U W.	BA	LTIM	URE	7	1,	15/4-LTI	MUR	ct mi	121223
	Sta Registr		31. Date filed (Month, Day, Year)	DEN AS	istrar's Signat	A see	A. P							

State of Maryland / Department of Health and Mental Hygiene 200628786 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 10, 2006 3:15 **Physician** Jovce Victoria Ertel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth April 25, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland Months 1 ☐ M 2 🕅 F 80 Yrs. 213-20-3069 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County or 28a-f show the Medical Exemple: must be notified at 1 ☐ Yes 2 ☑ No Baltimore Catonsville Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA or Itama 23a 5741 Edmondson Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Dept. Store Manicurist 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fils Department of Heelith and Mental Hy Important: if Item 27 is marked oth any july or other traumatic event 2008: Be Gorman Arthur Keeney Ida Mae Dean 9b. Majung Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Rockhill Ayenue Baltimore, Maryland 21229 19a. Informant's Name/Relationship (Type, Print) Lois Buhl, Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 09/11/06 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain **Physician** ow years IVMeur /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy signed by the ette Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypothypeidiem 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 2D No 1 Yes Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.
To the Funerel Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide o the Hospital 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 11, 2006 Kaya MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Form Rd Site 4A, Bult, MD-21227

ALETHA RAJA MD 4867 HOllins Form Rd Site 4A, Bult, MD-21227 3 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 2 2006 Registrar

		1	For State Registrar	ate of Maryland / D		ment of He ficate of D		ental Hyوا ا	giene, Reg. No. <b>(</b>	2006	28787
			I. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
	Physicia		Helen Elizabeth E	bert						8, 2006	4:45 P M
	/Medic Examin		la. Facility Name (If not institution, give street	and number)	4	b. City, Town, or	Location of Death			County of Death	
	<u></u>	•	117 Ravenswood Co	urt		Joppa		,		rford	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	N	Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Yeer)		place (State or Foreign htry)
	Director		216-20-3137	80 Y	Yrs.			May 28,	_192	6 Mary	land
	p ,	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Local	ion					10d. Inside City Limits
	shov	5		Joppa							1 ☐ Yes 2√2 No
	he M	Director	Maryland Hartord  10e. Street and Number	Оорра		10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	with be or					21005			US	27	
	eath	era	117 Ravenswood Court	as Decedent Ever in U.S.	13. Wa	21085 s Decedent of Hi	spanic Origin? (S)	ecify Yes or No		14. Race - Ameri	
	ter d	Funeral	1 Never Married 2 Married 1	med Forces? ☐Yes 2€ No		es, specify Cuba ]Yes 2 <b>⊠</b> No	n, Mexican, Puerti Specify:	o Hican, etc.)		Black, White, Specify:	, etc.
936	urs al	by		Yes, Give ear or Dates:	1 1	Yes 2LZNNO	Spacity.				ite
Ō	72 ho	Completed	15. Decedent's Education (Specify only highest grade com		Deceder	it's Usual Occupa	ation furing most of wor ()	king	16b. Kir	nd of Business/Ir	ndustry
21	thin i	nple	Elementary/Secondary (0-12)	olloge (1-4or 5+)	iite DC Omema		)		Ov	vn Home	
2	ygien ygien yer th	Co	12	110	OHETH	inci	18. Mother's Nan	ne (First Middle			
p	be fill d oth	Be	17. Father's Name (First, Middle, Last)							,	
<u> </u>	should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or items 23e or 28e-f show umatic event, I're Modical Examiner must be notified a	유	Fdward (unk) Clancy 19a, Informant's Name/Relationship ( <i>Type</i> , P	trint) 10h	h Mailing	Address (Street)	ALMA (U and Number or Ru	nk) Palt		r Town, State, Zi	p Code)
Maryland 21215-0036	12 sh h and 7 is m iraum						r Ct., J				
a)	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, Ire Modical Examiner must be modified at		Nancy E. Beyer / Daug 20a, Method of Disposition	20b. Place o	of Disposit	ion (Name of	- 2	Date	20c. Lo	cation - City or T	own, State
وّ	ages nt of l		1 ☐ Burial 2 Tremation 3 ☐ Remo	val from State		tory or other plac	l l	1_06	Пок.76	son, Mar	wl and
Baltimore,	it. Partme		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Six attire of Funeral Service Ligansee</li> </ul>	Hille	1 22.1	Name and Addre	corp 9-1				
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.		Dally March	an Almixt	M	Comas F	uneral H	ome, P.	A adon	. Maryla	and 21009
			23a. Part1. Enter the disease, or complication	ns that caused the death. Do	not enter	the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
		3 1	shock, or hear failure. List only one ca	ordio pr	200	nana	111	70 K K O	Pro		Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	of):	1010	- Jun	200			
	Examiner			NSVD	>						
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):						
	cuted	Examiner	that initiated events C								
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence	e of):						
8760,	cate be executed oblysician and the burial-transit	dical	d								
9	the death certificate y the attending phys iched for use as the	1 0	IF FEMALE:	f yes, outcome of pregnancy						23d. Date of deli	verv
Вох	eath certific attending p I for use as I	Physician/M	23b. Was decedent pregnant	t yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		ctopic pregnance	/			Month	Day Year
0.	at the dea by the a stached f	ysic		9 Unknown	30	эттөг (эрослу) _					
Ρ.	that thed the		Part II. Other significant conditions contribu	uting to death but not resulting	in the und	lerlying cause gr	en in Part I.	23e. Did	tobacco (	use contribute to	the cause of death?
ds,	signed d be de	d by						10	Yes 2	19/No 3□ Pr	obably 4 Unknown
Records,	The law requires that ite has been signed b bage 2 should be deta	Completed						24a. Wa:		24b. Were au	topsy findings available
Rec	ne lav n has ge 2	m d							opsy ormed? 2 <b>X</b> No	death?	completion of cause of
all		e Co	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only		7,3,103	74.0
Vital		o B	examiner?	ital: 1 Inpatient 2 ER/C	Outpatient	3□ DOA Ott	200			6 ☐Other (Spec	cify)
of	g Physter this neral di	1	27. Manner of Ceath 2		. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how inju	ry occurred	
ion	Attending r death. actor: After by the fune	atio	Natural 5 Pending investigation	(Monal, Day 10a)	wqury		Yes 2□No				
Division		ific	3 Suicide 6 Could not be determined	8e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Au e)	ural Route Number,
ā	safter safter al Dira	Certification:						1			
	Hospita 24 hours Funeral etely filled		29a. Certifier (Check only 2 Medical Examiner:	en: To the best of my knowledge On the basis of examination a	lge, death and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s e, date an	<ul> <li>and manner as d place, and due</li> </ul>	s stated. to the cause(s)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Diractor: At completely filled in by the fu	Medical	one)	and manner stated.	_		se number			ate signed (Mont	
	To the within To the comple	1	29b. Signature and title of certifier	16.10W	)	100	8480		C	111/00	·
	6		the 11	loted agues of don't them so	a) (Turn !	Print Flat	Sokalı			1111106	
	12		30. Name and address of person who comp	leted cause of death (Item 23a	a) (Type, I	rint) Flet	1709E				
		tate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	The same	To all a					
	Regis	tate trar	SEP 1 2 2006	A tour St.	The state of the s						

				partment of Health and M ertificate of Death		ene <sub>3. No.</sub> 2006 2878	8 (
	Physicia	an	1. Decedent's Name (First, Middle, Last) FLORENCE ELAINE FULLER		2. Date of Death Month Septem	ber 8,2006 3. Time of Death 8:20 A	А
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 58 Yrs	Months Days Hours Min.	8. Date of Birth	9 Birthplace (State or Foreig Country) 1,1948 North Carolin	n B
	anyland ehow	ž	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o  MD Baltimore Be	Location altimore		10d. Inside City Limits	- 1
	with the M s or 28a-f be notifie	Directo	10e. Street and Number 7115 Sandown Circle #202	10f. Zip Code 21244	109	g. Citizen of What Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Mailical Examiner must be coulded at once.	Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes Six No If Yes Give	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	ithin 72 hour le. lan "naturel" le Maulical Ex	npieted b	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation live kind of work done during most of working. b. DO NOT use relified) Payroll Special	ng	6b. Kind of Business/Industry Visiting Nurses Association	
land 21	ld be filed w ental Hygier ked other th ic event, th	To Be Cor	12 17. Father's Name (First, Middle, Last) Fletcher Lamm	18. Mother's Name Iris M.	(First, Middle, Ma		
, Maryland	ath and M			ailing Address <i>(Street and Number or Rura</i> 22 Point Seneca			
altimore,	Pages 1 at the month of the mon		1XX Purial 2 ☐ Cremation 3 ☐ Removal from State Morela: 4 ☐ Donation 5 ☐ Other (Specify)	orematory or other place) and Memorial  erk	2-06 F	Oc. Location · City or Town, State Parkville, Maryland	- 12
Ball	Departition Depart			22. Name and Address of Facility EVA 8800 Harford Roa	d-Parkv	rille,MD 21234	
50,	Physician and Marial Itansit the parial Itansit	ıl Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)	enter the mode of dying, such as cardiac of	r respiratory arres	st, Approximate Interval Between Onset and Death	2
P.O. Box 68760,	the death certi y the attending ched for use a	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
	signed be de	by	Part II. Other significant conditions contributing to death but not resulting in the Description of the Corollates in th	e underlying cause given in Part I.		acco use contribute to the cause of death? s 2 ☑No 3 ☐ Probably 4 ☐Unknow	'n
II Reco	The ate h page	Completed	disease		24a. Was an autopsy perform	prior to completion of cause of death?	le
Division of Vital Records,	ding Physician: Th Ih. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1	e of 28c. Injury at		nce 6 Sther (Specify) Hospice	
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28I. Location (Stre City or Town,	eet and Number or Rural Route Number, State)	
	To the Hospital of within 24 hours at To the Funers! Completely filled it	edicai	29a. Certifier (Check only one)  1. **Certifying Physician: To the best of my knowledge, continuous and manner stated.	eath occurred at the time, date and place, in investigation, in my opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)	
	To To Commo	W	29b. Signature and title of certifier  Arthury Riley: ms	29c. License number D 2 5 2 d 5	5	use(s) and manner as stated.  te and place, and due to the cause(s)  d. Date signed (Month, Day, Year)  Experience 8, 2006	
	6		30. Name and address of person who completed cause of dath (Item 23a) (Ty  W. A. R. Ley G. BM C 6701 N	po. Print) - Charles St. Bal	L. md	2120k	
	Sta Registi		31. Date filed (Month, Day, Year)  SEP 1 2 2006  32. Jegistrar's Signature	operale.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 28789 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle, Last) Month Day Physician Marie Therese Simone Juste Florestal 1423 September 8, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac 7980 Inverness Ridge Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs. October 15, 1935 Haiti Director None Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar I suit be notified at 1 ☐ Yes 2 No Potomac Maryland Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20854 Haiti 7980 Inverness Ridge Road death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or Ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: ģ 3 ⅓ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nunize Joassaint Mecene Juste 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7980 Inverness Ridge Road, Potomac, Maryland 20854 Marie D. A. Ketleen Florestal 20b. Place of Disposition (Name of cemetery, crematory or other place Parc du Souvenir Cemetery 20c. Location - City or Town, State 20a. Method of Disposition September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Port-au-Prince, Haiti permit. Page Department of Important: if eny injury or once. 16, 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cervical Cancer 9 Months Physician /Medical Due to (or as a consequence of) Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Deep Venous Thrombosis Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 sl autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending 1 ☐ Yes investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier t 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KHludener M.D. D59013 September 11, 2006

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konstantin Khludenev M.D. 15825 Shady Grove Road, Suite 140, Rockville, MD 20850

			For State Registrar		State of Ma	aryland /	Depa <i>Cer</i>	irtment of F tificate of	lealth and <i>Death</i>	Mental Hy	giene Reg. No	200	6 2	8790
	Physicia	3.0	1. Decedent's Name (Firs	t, Middle, Last)						2. Date of De	aath		3. 1	ime of Death
	/Medic	al	Henrietta A.  4a. Facility Name (If not in					4b. City, Town, o	r Location of De			.U, 2006 County of De		
	Examin	er	536 E. 38th S	-	reet and number)			Baltimo				N/A		
100	Funeral Director		5. Social Security Number 220–50–3396	r 6. Sex	- X -	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mil		th ay, Year)	.948 Ir	irthplace ( Country) Idiana	State or Foreign
	D D		Usual Residence of Dece	dent		10c. City, T	oum or Lo	cation					10d In	side City Limits
	Aaryia f shov	ō	10a. State 10b.  Varyland	N/A		Baltin		Callott						Yes 2 No
	r 28a-	Director	10e. Street and Number	11/71		Daren	ioi c	10f. Zip Code			10g. Cit	tizen of What (	Country?	\
	th with	al D	536 E. 38th St	reet				21218			US	SA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23s or 28s-f show eny injury or other traumatic event, I'm Medical Exeminations must be untilled at Once.	by Funeral	11. Marital Status  1 Never Married 2 3 Widowed 4	Married	<ol> <li>Was Decedent Armed Forces?</li> <li>1 ☐ Yes 2 ☐ X</li> <li>If Yes, Give Year or Dates:</li> </ol>		l.	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 仅 No	dispanic Origin? an, Mexican, Pue Specify;	(Specify Yes or North Rican, etc.)	0-	14. Race - An Black, Wh Specify:		dian,
21215-0036	thin 72 hou e. en "neture Medical I	Completed by	15. [ (Specify on Elementary/Secondary	Decedent's Educity highest grade	ation completed) College (1-4or :		(Give life. L	dent's Usual Occup kind of work done OO NOT use retire	during most of w d)	orking		ind of Busines	s/Industry	
	led wi		12 17. Father's Name (First,	Middle ( ast)			Phan	macy Techn		ame (First, Middle		armacy		
anc	d be fi	To Be	Hubert Franss							e Zazads	, maidon			
Maryland	shoul and Ma mari umati	F	19a. Informant's Name/F			11.		g Address (Street				or Town, State	Zip Code	)
	and 2 ealth a m 27 to		Barry Guralnic			Tank Bi		. 38th Stre	et Balti		,	21218		
Baltimore,	Pages 1 ment of H ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cre 4 ☐ Donation 5 ☐	mation 3 Re	moval from State	сет	etery, cren	sition (Name of natory or other pla	9/14	Date		ocation - City on Maryla		tate
Balt	permit. Depert Import eny inj		21. Signature of Funeral	Service License	Hilto	n	1 1 5 3	Name and Addre	ess of Facility UCK Road Ba	Itimore Mai	ryland	1 21214	- 1	
	Physician and // // // // // // // // // // // // //	Examiner	23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, ate	Due to (or as	a consequent a consequent	(ce of):	o Cal	dial	ac or respiratory	accept,	Cleor	Inter	oximate val Between et and Death
8760,	cate be cate by thy sicial	dical		€ d.										
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mon 1 □ Yes 2 ☑ No 9 □ Unknown	mant	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	]Ectopic pregnanc ] Other (s <i>pecify)</i> _	у			23d. Date of d Month	lelivery Day	Year
Δ.	uires that signed b	ρ	Part II. Other significant	conditions con	tributing to death t	out not resulting	in the u	nderlying cause gr	ven in Part I.			use contribute		use of death?
Division of Vital Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed			-		1	0		24a. Wa auto pen 1 🗆 Yes	s an opsy ormed? 2 1 No	prior t death	o completi	ndings available on of cause of
/ita	Physician: Th this certificete al director, pag	Be	25. Was case referred to examiner?	1	ospital:			0+		eath (Check only	one)	-		
of	Phys this ral dir	. To	1 Yes 2 No		1 Inpati 28a. Date of Inju		Outpatier  b. Time o	IL 3LIDOA		Home 5 Home 28d. Describe			pecify)	
O	Attending Phir death.  ctor: After this by the funeral	atlon		Pending investigation	(Month, Da	ay Year)	Injury	Wo	rk? ]Yes 2 □No					
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Sertification:	3 Suicide 6 (	Could not be determined		jury - At home tc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To		nd Number or e)	Rural Rou	te Number,
	le Hospital or 124 hours afte le Funeral Dir lietely filled in I	ledical C	29a. Certifier 1 (Check only 2 one)	Certifying Phys Medicel Exemin	icien: To the best er: On the basis of and manner si	of examination	edge, deat n and/or in	h occurred at the t vestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s , date an	and manner d place, and d	as stated. ue to the o	cause(s)
	To the within To the comp	Me	29b. Signature and title	of certifier	Dee	e		29c. Licen	se number 26 7 4 8	2	91	ate signed (Mo	nth, Day,	Year)
	5		30. Name and address of	person who co	g led	60	Jke	Print)	2121	DR.	Anil	06	10	,
	Sta Regist		31. Date filed (Month, Da	1 2 2006	32, Regist	rar's Signarur	8	als)						

			1 - For State Registrar	State of Ma	ryland /	Cer	artment of F tificate of I	lealth and Death		giene Z (	JUb	2879
	Physici	an	1. Decedent's Name (First, Middle, La IDA	MAE	GATTO	)N			2. Date of Dea Month Sept.	Day	O O O	3. Time of Death 12:31 a M
3	/Medio Examin		4a. Facility Name (If not institution, giv	e street and number)	<u>.</u>		4b. City, Town, or	Location of Dea		4c. County		12.51 4
			Mariner Health & 1					Burnie			Arur	
	Funeral Director		5. Social Security Number 6. S 298–18–4768 1  Usual Residence of Decedent	ex 7. Age	(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthp Cour Kent	place (State or Foreign htry) CUCKY
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	e Mar	ctor	Maryland Anne A	rundel		Pas	sadena			-		1 ☐ Yes 2 🗹 No
	death with the Maryland me 23a or 28a-f show	ai Director	10e. Street and Number 8153 Armiger Dri	ve			10f. Zip Code 211	22		10g. Citizen of U.S		ntry?
2-0036	filed within 72 hours after death with the Marylar thygiene. ther than "natural", or items 23a or 28a-f show this it is margical Examiner marks notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 M N If Yes, Give Year or Dates:	ver in U.S.	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 212 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: Wh	
6		lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	Give	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of B	usiness/In	dustry
7 1 7	be filed withintal Hygiene. Id other than event, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)		sewife	,		Н	ome	
yland	~ - 0 -	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumar		
		ဥ	Unkown		naffen				Unkow			
<u>z</u>	s 1 and 2 should f Health and Mer item 27 is marke other treumstic		19a. Informant's Name/Relationship ( Wilbur R. White		19		g Address <i>(Street :</i> 3 Armiger					
nore,	Pages 1 ar		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemet	of Dispo	sition (Name of	·e) [	Date	20c. Location	City or To	
Банито	permit. Pages 1 Depertment of H Important: If ite any injury or ot		21. Signature of Emberal Service Licer	'	MANI		Name and Address Cully-Po 204 Mount	1				=
ı			23. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	yranc	Approximate Interval Between
	Physician /Medical	6	Immédiate Cause (Final disease or condition resulting in death)	/ -	HONCH	06	ENIC (			4		Onset and Death
	Examiner		Sequentially list conditions	b	0011004001100	2 0.17.						
	ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	ol).						
og,	ificate be executed g physicien and as the burial-transit	ai Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						=======================================
00/00	ificate g phys	edicai		d								
.C. DOX	sician: The law requires that the death certific certificate has been signed by the ettending p rector, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b Was decedent pregnant n the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	Fetal deat		Ectopic pregnancy Other (specify)				te of delive	ory Day Year
cords, r	quires that n signed build be det	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did to		nibute to th	ne cause of death?
ī.	The law rea ate has bee page 2 sho	Completed							24a. Was a autop: perfor	med?	Were auto prior to cod death? 1  Yes	psy findings available impletion of cause of 222 No.
<u> </u>	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			100		ath Check only or			
5	Physic r this ral dir	٠. ح	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatier		utpatien Time of		4 Mursing r	Home 5 ☐ Resid			"
0	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injun Work	k? Yes 2 □No		,.,,		
DIVISION OF	ai or Atte s efter dez if Directo id in by th	Certification:	3 Suicide 6 Could not be determined		y - At home, f (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or Attending Physician: The I within 24 burs elter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier 12 Certifying Ph	ysician: To the best on the basts of and manner states.	examination a	ge, death nd/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occi	e, and due to the durred at the time, o	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	To the complete of the complet	Σ	29b. Signature and title of certifier	u mu	una-		29c. License	7 7 53	Z	29d. Date signe	d (Month,	
	4		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, I	372/ F	POTEE	Sh. BA	-		12225
İ	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 200	29	's Signature	64.3	de la					

		4	1 - State of Maryland / St	Department of Health and Me Certificate of Death	ental Hygien Reg. N	2006 28 <b>7</b> 92
ì	Physici /Medic	an	1. Decedent's Name (First, Middle, Last)  Dorothy T. Gondeck		2. Date of Death Month Deptember	7 2006 7:2/pm
	Examin	er	4a. Facility Name (If not institution, give street and number)  Union Memorial Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birt)  1 □ M 2 ☒ F  7. Age (In yrs. last birt)	Months Days Hours Min.	8. Date of Birth	N/A  9. Birthplace (State or Foreign
	Director		214-26-3716		Aug 20, 1	927 Mary Land  10d. Inside City Limits
	Maryla a-f eho	to		altimore		1 XYes 2 ☐ No
	with the	Directo	10e. Street and Number 833 West 38th. Street	10f. Zip Code 21211	10g. (	Citizen of What Country? USA
36	be filed within 72 hours after death with the Maryland nat Hygiene. nd other than "natural, or items 23a or 28a-f ehow event, the Medical Examinar must be untilian at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married   1 □ Yes 2 ♥ No   1 □ Yes 2 ♥ No   1 □ Yes Give 1	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	city Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
215-0036	in 72 hour n "natural" Vedical Ex	Completed b	Λ	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	g 16b.	Kind of Business/Industry
7	filed with Hygiene other the	Com	12	Business Owner	(First, Middle, Maid	Self Employed
Maryland	id be fil lental H ked otl ic ever	To Be	17. Father's Name (First, Middle, Last)  Harry A. Kraft		E. UNK.	ar damano,
lary	2 should be and Mental ie marked c	-	19a. Informant's Name/Relationship ( <i>Type, Print</i> )	. Mailing Address (Street and Number or Rural		
altimore, N	ss 1 and of Health litem 27 r other ti		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	ry, crematory or other place)	ate 20c.	Maryland 21227  Location - City or Town, State  odlawn, Maryland
Baltin	permit. Page Department important: if eny injury o		21. Signature of Funeral Service Utensee  Thomas Gregor	22 Name and Address of Facility MacNabo Funeral Ho	me, P.A.	lle, Maryland 21228
8760,	Physician and busicien and physicien l Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of the	Arrest al Infarction		Approximate Interval Between Onset and Death 60 minutes	
P.O. Box 68	The law requires that the death certifica ste hes been signed by the ettending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 WNo 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	juires that t n signed by ald be deta		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?  2 No 3 Probably 4 Dunknown
Division of Vital Records,	: The law require cete hes been si , page 2 should l	Completed	2 300 000 000 000 000		24a. Was an autopsy performed 1 ☐ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Vita	sician s certific	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ₹ No  Hospital: 1 □ Inpatient 2 ₹ ER/O	26. Place of Death  utpatient 3□ DOA Other: 4□ Nursing Hor		6 □Other (Specify)
ion of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	-	27. Manner of Death 1 Dentatural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)		28d. Describe how in	
Divis	tel or Atters after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Roule Number, ate)
	the Hospitel hin 24 hours a the Funerel mpletely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledg Medical Examiner: On the basis of examination are and manner stated.		ed at the time, date	
)	To with	-	29b. Signature and title of certifier  29b. Signature and title of certifier  20 Name and address of an auto completed cause of death (Item 23a)	00054003	3 Se	optember 8, 2006
	5		30. Name and address of Isin who completed cause of death (Item 23a)  William Fronka Wildin	Memoral Hospital	Jalhin	ere MO 21218
*	St Regist	ate rar	31. Date filed (Month, Day, Year)  SFP 1 2 2006  32. Registrar's Signature	Spelle		

			For State Registrar	State of Ma		epartment of Certificate of		nd Mental Hy	giene200	5 28793
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, L	House	od	4b. City, Tow	n, or Location of	2. Date of De Month Death	Ac. County of Do	eath
	Funeral Director			Sex 7. Age	(In yrs. last birth	day) If Under 1 Yes		Min. B. Date of Bird (Month, Da	th 9. E	Birthplace (State or Foreign Country)
	Be-f ehow	ector	10a. State 10b. County  MD Harford		10c. City, Town	sville				10d. Inside City Limits 1  Yes 2 No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 le marked other than "natural; or Items 23a or 28e-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral Director	10e. Street and Number  3845 Norrisvill  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	e Rd.  12. Was Decedent E Armed Forces?  X□Yes 2□N If Yes, Give Year or Dates:			084 of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	USA  14. Race - Al Black, W  Specify: T	πencan Indian, hite, etc.
21215-0036	filed within 72 hou Hygiene. kher then "neture int, the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education Erade completed)  College (1-4or 5- n/a	+)	Decedent's Usual Oc Give kind of work do life. DO NOT use re chanic	nne during most o tired)		16b. Kind of Busine	·
Maryland	2 should be fill and Mental Hi le marked oth sumatic even	To Be	17. Father's Name (First, Middle, La:  Joseph Waltman  19a. Informant's Name/Relationship	Heacock	19b. I	Mailing Address (Str	Carol	s Name (First, Middle, ine Isenno or Rural Route Numbe	ock	a, Zip Code)
	Pages 1 and 2 nent of Health a int: If Item 27 Is		Fay Marie Ward/ 20a. Method of Disposition 1 1 Burial 2 □ Cremation 3	☐Removal from State	20b. Place of C	5 Norrisva Disposition (Name o. Crematory or other Y Valley 1	nlacel	) Jarretts 9/6/06	20c. Location - City	or Town, State
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Sin all forms of W. Clar	nset de		Lemmon Fi	dress of Facility ineral H ionia Rd	ome of Dul		gy, Inc.
8760,	Physicien and ph	lical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	consequence of	1 Ark Fai	dying, such as co	ardiac or respiratory a	D	Approximate Interval Between Onset and Death
P.O. Box 68	i that the death certifical ned by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of o	delivery Day Year
Records, P.	law requires as been sign 2 should be	Completed by Ph	Part II. Other significant conditions	s contributing to death bu	t not resulting in	the underlying cause	given in Part I.	24a. Was autor period	an 24b. Were prior death	
Vital	sician: The law certificete has b irector, page 2 s	Be Co	25. Was case referred to medical examiner?				26. Place o	1 ☐ Yes of Death (Check only o	No 1 Y	es 2 No
o	ng Phy Iter this ineral d	၉	1 Yes 2 No  27. Manner of Death  Natural 5 Pending 2 Accident investigat			me of 28c. I	Cther: 4 Nurs njury at Work? 1 Yes 2 Ne	28d. Describe	dence 6 □Other (S how injury occurred	pecify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, farr (Specify)	m, street, factory, off	ice	28f. Location (. City or To	Street and Number or wn, State)	Rural Roule Number,
	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in its	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination and	death occurred at the for investigation, in r	e time, date and ny opinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and o	as stated. lue to the cause(s)
	To th To th comp	W	29b. Signature and title of certifier				ense number	9-01	29d. Date signed VMC	onth, Day, Year)
	4+		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (1	ype, Print)	Bult	imore,	MD 21	204
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 2	32. <b>He</b> gistra	r's Signature	Sparks.	0,00001			¥

06-06572 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Arthur Hebb 1- For State Certificate of Death Reg. No. Registrar 2 Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 1230 hrs 2006 **Medical Examiner** Hebb September 2, I. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2754 West Mosher Street 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** oreign Country) Months Days Hours Director 54 04 04 MD 52 220-64-8496 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 X Yes 2 No s 23a or 28a-f show Baltimore or 28a-f show NA MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21216 U.S.A. ◱ 2754 West Mosher Street permit. Pages I and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be not Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Black 4 Divorced If Yes, Give Year Specify: 3 Widowed 1 Yes 2 X No specify: þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 School Janitorial llth grade na 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Emma Saxon Be Arthur I. Hebb 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD 1001 Ashburton Street, Baltimore, Md 21216 Patricia Hebb-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Xurial 2 Cremation 3 Removal from State Randallstown, Md 9/8/06 Memorial Park Kinq Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West 21 Signature of Funeral Service Aicensee Baltimore, Md 21215 4300 Wabash Ave, Approximate Interval er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Part I. Er **Physician** Between Onset and failure. Ais only one cause on each line. M-dical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown q Linknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Records, P. Diabetes The law requires Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No this certificate 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician; Division of Vital Be Other; Hospital: 1 DOA Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 FR/Outpatient 3 ို 1 Yes After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Director: d in by the f Pending 24 hours after death. 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie September 3, 2006 O.C.M.E. 30. Namula Jacob ess of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela Southall, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	/ Departme	nt of Healt ate of Dea	h and Mental H	ygiene 20 (	06 28795
<i>)</i>	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  TO HN  4a. Facility Name (If not institution, give st  HARBOR HOS IN TOL  5. Social Security Number  6. Sex.	ree( and number) Cowler 7. Age (In yrs. la:		100	on of Death	Day Ye 4c. County of E	Death  Birthplace (State or Foreign Country)
	Funeral Director			M 2□F 74	Yrs. Month Town or Location	s Days Hou	rs Min. (Month, t March	24,1932	Maryland  10d. Inside City Limits
	death with the Maryland sms 23a or 28a-f ehow ir maat be notified at	Director	Maryland Baltime		Lansdo	OWNE		10g. Citizen of Wha	1 Tyes 2 No
0036	hours after death wi urel', or Items 23a Examiner must be	by Funeral D	3228 Magnolia Aver	☐UC  2. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	1	21227 cedent of Hispanic pecify Cuban, Mex 2 No Spec	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	U.S.A.  14. Race - A.  Black, V.  Specify:	American Indian, White, etc. White
00-CLZ12	d within 72 hour jiene. Ir than "natural	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation		sual Occupation work done during to use retired)	nost of working	16b. Kind of Busine Sears Roe	ess/Industry
yland	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Clayton G. Hi				other's Name <i>(First, Middle</i> Anna V .	Markell	
e, mar	1 and 2 she Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Typ Dorothy L. Hunter  20a. Method of Disposition	(Wife)	-	gnolia Av	mber or Rural Route Num enue, Baltin Date		land 21227
Baitimor	permit. Pages Department of Important: if it any injury or o		1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)  21. Signature of Funeral Service License	New	Cathedra	1 Cem.	09-15-06	Baltimore,	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. a cause on each line.  Due to (or as a conseque					Approximate Interval Between Onset and Death
68/60,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence LLA)  Due to or as a consequence LLA	l fa	lurl	lar dis	00°2 (	unknown
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Hecords, P	w requires that the d been signed by the should be detached		Part II. Other significant conditions continued in the	ributing to death but not result	ting in the underlying	cause given in P	1	. /	te to the cause of death?  Probably 4 []Unknown
Vital Reco		<b>Completed</b>	effection of the control of the cont	Right 70	y dysp	hagia	per 1□ Yes	opsy prior formed? deat 2/√√ No 1 □	e autopsy findings available r to completion of cause of th? Yes 250 No
	a ii a	To Be	avaminu/?	28a. Date of Injury 2	R/Outpatient 3 28b. Time of	Other	lace of Death (Check only  Nursing Home 5 Re 28d. Describe		Specify)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific compisiely filled in by the funeral director,	Certification;	1 K Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)	Injury M ne, farm, street, fact	1 ☐ Yes	28f. Location	(Street and Number of own, State)	or Rural Route Number,
	ne Hospita 1 24 hours ne Funera Metely fille	Medical C	(Check only one)  2.12 Contifier 1 Contilying Physical Contilying Physical Examination (Check only one)	ician To the best of my know er: On the basis of examination and manner stated.	ledge daath Jonum on and/or investigati	ed at the time date on, in my opinion,	e and clace, and due to the death occurred at the time	a cause(s) and manne a, date and place, and	due to the cause(s)
•	To th Withir Comp	Ĭ.	29b. Signature and title of certifier	Kin MD	2	29c. License numb	per 3	29d. Date signed (A Sep. 11.	fonth, Day, Year)
1	<u> </u>		30. Name and address Alerson who con	n HD. 3001.	S. Haeno	VER S	t Baltim	020, MD .	21225
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire .	W.			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ARGARE 10:20 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Onder 1 Year III Under 24 Hrs. HARBOR HOSPITA BALTIMORE CITY Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗙 F Vrs Director 271-22-3083 79 AUG. 2, 1927 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No MARYLAND | ANNE ARUNDEL GLEN BURNIE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 802 SCOTT CIRCLE Funerai death 1 21060 UNITED STATES iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3X Widowed 4 ☐ Divorced "naturel", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7.27 is marked other than "y traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (UNKNOWN) WILSON (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other trau once. 9384 MEMORY RD. PAMELA WOOD / DAUGHTER GREENWOOD, DE 19950 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition SEPT. 14, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 CROWNSVILLE MD VET. CEM CROWNSVILLE, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST Physician /Medical Due to (or as a consequence of) Examiner NEUMONI S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. physician by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death ed by the a O 9 Unknown Division of Vital Records, P. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 217 No 24a Was an has autopsy performed? certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 V Inpatient 2 2 ER/Outpatient 3 DOA this After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a
To the Funeral C To the Hospital 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANGPING JIA 3001 SOUTH HANOVER ST. BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

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Vivian	F	Hantz

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 6, 2006 **Medical Examiner** 1641 hrs 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number 4c. County of Death 2312 Winchester Street Apt. I Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY Funeral Foreign Days Months Hours Directo Country) 2 X F M Yrs Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show notified at once, more Director 10e. Street and Number 10g. Citizen of What Country Apt. or items 23a Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes If Yes, Give Year hours after Divorced 1 Yes 2 No specify: Specify. ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Indus Completed 2 should be filed within 72 h i and Mental Hygiene 27 is marked other than "n Elementary/Secondary (0-12) the Medical Baltimore, MD 21215-0036 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maider Be 19b. Mailing Address Informant's Name/Relationship (Type (Street and Number or Rural Route Number, City State, Zip Code) If item 27 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 2 Cremation 3 Removal from State crematory or other place) Y Burial Donation 5 Other Specify Signature of Funeral Service License Name and Address of Facility Joseph aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication allure. List only one cause on each line Approximate Interval Physician Between Onset and /M-dical Death Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate Enter Underlying Cacina (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g859,9/18/06 TT Box 62760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed ision of Vital Records. 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes 25 Was case referred to medica 26. Place of Death (Check only one) examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work 28d. Describe how injury occurred Yes 2 X No 5 Pending Fnd 9/6/2006 Fnd 4:30 pm unk Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2312 Winchester Street Apt 1, Baltimore, MD 24 hours after Funeral Div 6 X Could not be Suicide ä (Specify) Homicide residence 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E September 7, 2006 JR, Mu V) 30 Name and address of person w o complet > cause of d th (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day, Year)

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	Physici /Medic Examin	al	4
I	Funeral Director		5
3500-91212	d within 72 hours after deeth with the Maryland giene. In then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	Completed by Funeral Director	

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	/Medic		Philip	Charles		Hank				1- 1	Septer				2:00	) P M
	Examin	er	4a. Facility Name (If not institution, giv 5225 Pooks Hill	Rd., Apt	. A29				hesda	a				tgom		
1	Funeral Director		5. Social Security Number  196-24-9416  Usual Residence of Decedent	Tex 7. Age	75	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da May 15	y, Year) 19:	31		ace (State ry) Jerse	
	land w		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10	d. Inside C	City Limits
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Baltimore,	ages 1 int of H t: if ite y or ott		20a. Method of Disposition  1 ☐ Burial 2\( \) Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		C	lace of Dispo emetery, crer esapea	matory or o	other place	-		IO6		cation - C	•	vn, State .e, MI	`
altir	mit. Poartme		21. Signature of Funeral Service Licer	alds.	0038	. 22	2. Name ar	nd Addres	s of Facili	ty	, ,				e, m	,
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	104		30. Name and address of person who				Print)					-/-	1852			
		•	Genevieve Wro	blewski M. 32. Registra			- At		• , K	JCKVI	116, M		)852			
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	Physici		1. Decedent's Name (First, Middle, Last) Rosemary A. Hais1	in				2. Date of Dea Month SEPTEM	th	3. Time of Death
	/Medio Examir	er	4a. Facility Name (If not institution, give s BitLTIMORE WASHINGT	ONMEDICAL CE	NTER	46. City. Town, or	) Burn	th i E	4c. County of D	
	Funeral Director		5. Social Security Number 206-18-3386 6. Sep 1 C	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. 925	Birthplace (State or Foreign Country) PA
	e Maryland ta-f ehow tified at	ctor	10a. State 10b. County  MD Anne Ar		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	3e or 28	I Director	10e. Street and Number  141 Louise Terrace	2		10f. Zip Code 2106	50	1	U.S.A.	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23e or 28s-f show styl figury or other treumatic event, the Madical Examinar must be notified at another.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - A	mencan Indian, /hite, etc. white
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Mary	id 2 sho Ith and It 27 Ie ma		19a. Informant's Name/Relationship (Ty) Mr. Robert Haisli						r, City or Town, Stat	, , ,
Baltimore,	Pages 1 and 2 ent of Health a nt: If Item 27 Ie ry or other tree		20a. Method of Disposition  1 Burial 2 Cremation 3 B  4 Donation 5 Other (Specify)	20b. Femoval from State	Place of Dispo cemetery, crer	e Cremati	:e)	Date	20c. Location - City Stevensvi	or Town, State
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f Vit	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatien	t 3 DOA Othe	00	ath <i>(Check only on</i> Home 5 ☐ Reside	e) ence 6 □Other(S	Specify)
Division of	ding After fune	Certification;	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work			ow injury occurred	
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•	To the within To the Comple	Σ	29b. Signature and title of certifier	Pause	ais	29c. License	1670		9d. Date signed (Mi	onth, Day, Year)
_	4,		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	P nt) OHA	uis A	21061	Even	
	Sta <b>Re</b> gistr	_	31. Date filed (Month, Cay, Year) SEP 1 2 2006	32. Registrar's Signa	San	le				

DHMH 17 Rev 1/2001

HAISLIP, ROSEMARY

State of Maryland / Department of Health and Mental Hygiene 2006 28800 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) C Month **Physician** 6,2006 2214 M Ruth Hempel okmber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Belair Upper Chesapeake Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan - 7, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 82 Yrs. 061-18-3721 Walton, NY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "naturel", or iteme 23a or 28a-f ehow traumatic event, the Modical Examinar must be notified at Fayetteville PA Franklin 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17222 USA 3393 Cook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 should be filed w h and Mental Hygier 7 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sheldon Brink Alma Taylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: If Item 27 is any injury or other trai 2709 Farmview Drive Fallston, MD 21047 Robert S. Lindsay / Son Sept 8, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ÆCremation 3 ☐ Removal from State Baltimore MD Bayview Crematory -5<sub>√</sub>□Other (Specify) 2006 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quent Examine use as the burial-transit ettending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): 60, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day signed by the et id be detached fo 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown نے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has this certificate 2 No 1 ☐ Yes 1 🗌 Yes Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After or Attending Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital e within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and titte of certifier 29c. License number SIRITHARA, 2112, BELDIAROAD, SUITEID, FALLSTON, MD21047 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSHA 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4000 Registrar

			. For	State of Maryland	/ Departmen	t of Health and	d Mental Hygi	ene	
			1 - State Registrar		Certificate	e of Death		9. No 2006	28801
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     VICTORIA	HARDGES			2. Date of Death Month	Day Year	3. Time of Death 259 0 M
	Examir		4a. Facility Name (If not institution, give s	street and number)	4b. City.	Town, or Location of Do	eath	4c. County of Death	
, <u></u>	Superial.		5. Social Security Number 6. Sex	7. Ade (In yrs. last	birthday) If Under			N/A 9. Birth	nplace (State or Foreign
74	Funeral Director			M 2 X F 87	Yrs. Months	Days Hours M	fin. (Month, Day,	Year) Col	CAROLINA
	rland ow		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	B Man	ctor	MD. N/A	BA	ALTIMORE				1√2 Yes 2 □ No
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow dical Evantrar must be notified at	Director	10e. Street and Number	N 7 7 72	10f. Zip	1214	10	ng. Citizen <i>o</i> f What Col USA	untry?
	ne 23	Funerai	5912 BURGESS 2	12. Was Decedent Ever in U.S.		dent of Hispanic Origin?	(Specify Yes or No-	14. Race - Amer	rican Indian,
) (	or ite	/ Fur	1 Never Married 2 Marned	Armed Forces? 1 ∐Yes 2♥ No If Yes, Give	If Yes, spec		uerto Rican, etc.)	Black, White	
Ö	hours turai',	ed by	3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	6a. Decedent's Usua		1 1	6b. Kind of Business/I	
21215-0036	within 72 ene. then "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)			rk done during most of	working	ob. Time of buomiosari	
	filed wil Hygien other th		5th		KITCH	EN HELPER		RESTAURAN	TT.
and	d be fi	To Be	17. Father's Name (First, Middle, Last) UNKNOWN				Name (First, Middle, N AH LADSO)	-	
Maryland	should and Men marke	-	19a. Informant's Name/Relationship (Type		_	(Street and Number or	Rural Route Number,	City or Town, State, Z	
	fealth fealth im 27 i				912 BUR of Disposition (Name	GESS AVEN			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 23 is or 28e-1 show amply journers if item 27 is marked other than "natural; or items 23 or 28e-1 show any higher other traumatic event, the Medical Evantmer must be notified at any injury or other traumatic event, the Medical Evantmer must be notified at angle.		20a. Method of Disposition  1 □ 8urial 2 □ Cremation 3 □ R  4 ☑ Donation 5 □ Other (Specify)	emoval from State	etery, crematory or o	FAITH ME	T. 15,200	06. Location - City or 1 06 S BALTO,	
alti	permit. Departmimporta any inju		21 Senature of Funeral Service License			nd Address of Facility			
. (1)	70 E 2 G		23a. Part1. Enter the disease, or compli	a. Mugge	1412	E. PRES	TON ST. E	ALTO MD.	21213 Approximate
	Dhysisian		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Inha 1	Pneixmor		st,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen-	ce of):	PICUITION	114		
	Examiner	-	Sequentially list conditions,	Due to (or as a consequent	co of):				
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consequent	CG 01/.				
0,	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequen-	ce of):				
68760		dicai		1					
Box 6	n certifi anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deli	very
.O. B	The law requires that the death certifics ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death				Month	Day Year
Ω.	that the	y Ph	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the underlying c	ause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	v requires been sigr should be	ted by	Diabetes Nellitus	, Depression,	dehydra	tion, Chron	DIC 10 Ye	s 2□No 3□Pro	bably 4 Donknown
Records,	s law requir has been s e 2 should	Completed	Kidney disease, C	Coronary arter	ry disa	75e	24a. Was ar autopsy	24b. Were aut	topsy findings available completion of cause of
alF	Physician: The lav this certificate has al director, page 2	e Cor	25. Was case referred to medical	,		Pi	perform 1 Yes 2	No 1 Yes	2 🗆 No
f Vital	Physician: r this certifica ral director, p	To Be	avaminar?	lospital: 1 ☑Inpatient 2 ☐ ER	/Outpatient 3 DC	Cthor	Death <i>(Check only one</i> ig Home 5 ☐ Reside		nfy)
n of	ding Ph n. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28		28c. Injury at Work?	28d. Describe ho		
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	M farm street factors	1 Yes 2 No	28f. Location (Str	eet and Number or Ru	ral Route Number
Div	s after s after al Dire ed in b	Certification;	4 Homicide determined	building, etc. (Specify)	,,,,	,,	City or Town	State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred and/or investigation	at the time, date and pl., in my opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		290	c. License number	2000- 29	d. Date signed (Month	
)			Tub khá	edugan		8	9555 5	eptember	r-082006
	3	11	30. Name and address of person who co	empleted cause of death (Item 23	(Type, Print)	willand A	ENAMA!	tos nita	/
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	- U/U / IU	1 HIAIN A	CIICI GII	(U) I (UI)	
1	Regist	rar	SEP 1 2 200	16 America . Me	A.c. N	à			

DHMH 17 Rev 1/2001

ORIGINAL

_			1 - For State Registrar	State of M	aryland	d / Depa <i>Cei</i>	artment of H	lealth and Death		giene 2006 Reg. No.	28802
	Physici	an	Decedent's Name (First, Middle, Last	•					2. Date of De.	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	ardinis e street and number) LUNC HDS		ndrick		r Location of Deat	01	4c. County of Death	nore
	Funeral Director		5. Social Security Number 6. S	9x 7. Ag □M 2 🗶 F	e (In yrs. Ia 81	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year) Col	oplace (State or Foreign untry)
			207-16-0258 Usual Residence of Decedent						Dec. 24	1, 1924 Penr	
	with the Maryland a or 28a-f ehow Le nutifiad at	ctor	10a. State 10b. County  Maryland Baltimor	re	,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No
	with th	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	untry?
	death	Funeral	8800 Walther Blvd	12. Was Decedent	Ever in U.S	S.   13. \	21234 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (5		USA 14. Race - Amer	rican Indian,
38	hours after or tree tural, or item	þ	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces: 1  Yes 2  If Yes, Give Year or Dates:			fYes, specify Cuba I□Yes 25x2No		to Rican, etc.)	Black, White Specify: Whi	
7 00 P	72 ho natur	Completed	15. Decedent's Ec (Specify only highest gra			(Give	lent's Usual Occup	durina most of wo	rking	16b. Kind of Business/l	
22	within ene. then	ompi	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retired	1)		Classes de	
200	be filed wil stal Hygien of other the	a)	17. Father's Name (First, Middle, Last)			Secre	cary	18. Mother's Na	me (First, Middle,	Church Maiden Sumame)	
Hendrick	should be filed with Montal Hygiene marked other the matter event, Italians	To B	Emidio (nmn) Dif	Berardinis	5				(nmn) F		
Mar	nd 2 should lith and Mer 27 is marke r traumatic		19a. Informant's Name/Relationship (				-			or, City or Town, State, Z. , Parkville	
$\mathcal{Z}_{\mathbf{a}}$	s 1 and 2 of Health item 27 i		Edward F. Hendric 20a. Method of Disposition	ks/ Husba	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	20c. Location - City or 1	
7 6	Pages Iment o tant: if jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ② Other (Specify	Removal from State Entombnen		-		1	3-06	Bel Air, Ma	rvland
Balt	permit. Departrimports any inju		21. Signature of Funeral Service Licen	Herk		Mo	Name and Address Comas Fu	ss of Facility neral Ho	me P.A.	Maryland 2	(4)
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each i	d the death.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rest,	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	a CC	PL	)					Onset and Death
	/Medical Examiner			Due to (or as	a conseque	ence of):					
	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):					
8760.	ate be executed hysicien and the burial-transit	ai Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):					
ဟ	age Py Py Py Py	edicai	•	d							
Box	eath cer ettendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	·		23d. Date of deliving Month	very Day Year
Division of Vital Records, P.O.	juires that n signed t	Completed by PI	Pauli. Other significant conditions of the condi	ontributing to death to	out not resul	iting in the ur	nderlying cause giv	en in Part I.		obacco use contribute to	
S	aw requir is been si 2 should	piete	Bronchiec	tasis					24a. Was	an 24b. Were aut	opsy findings available
Ä	sician: The law certificate has t irector, page 2 s	Cem	Palmonary H	uperten:	5101	)			autop perfo 1 ☐ Yes	rmed? death? 2 No 1 ☐ Yes	ompletion of cause of 2□ No
Vita	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital: V.			Oth		ath (Check only o		
Jo	ding Phys h. After this funeral di	n: To	1 Yes No  27. Manyer of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		R/Outpatien 28b. Time of Injury	t 3 DOA 28c. Injun Worl	4   Nursing F		lence 6 Other (Speciow injury occurred	ify)
Sio	tendir seath. tor: Af the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	1			M 1 🗆	Yes 2 □ No			
Divi	• Hospitei or Attend 24 hours after death • Funeral Director: A etsiy filled in by the fi	Certification:	4 Homicide determined	building, e	tc. (Specify)		eet, factory, office		City or Tov		
	To the Hospitel or Atterwithin 24 hours after de To the Funeral Direct completely filled in by the	ledicai	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination	vledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	urred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	ER-HIA	1:	MS	29c. Licens	o number (1) 1251		29d. Date signed (Month	Day, Year)
	10		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	2	Rail.	ore, md o	7/721
	Sta	ite_	31. Date filed (Month; Bay; Year).	32. Registr	rar's Signatu	1 / CU	WILL O	y wire	LUITIM	ure, ma o	ciacoj
	Registr		CED 1 9 7	nns I		21 1	mall B				

	•	1 - For State Registrar	State of Mary		artment of He tificate of D			giene Reg. No. 20	06	28803
Physicia /Medic		Decedent's Name (First, Middle, Last,  CARL	HARPER	2			2. Date of De Month 09	Day	Year	Time of Death
Examino Funeral		4a. Fecility Name (If not institution, give  SHOCK TRAVINA  5. Social Security Number  10	street and number)  x 7. Age (In	yrs. last birthday)	4b. City, Town, or I BALTIMO If Under 1 Year Months Days	RE	8. Date of Bir	th ny, Year)	9. Birthplace Country)	(State or Foreign
Director  word and and and and and and and and and an	tor	442-38-1171  Usual Residence of Decedent  10a. State  10b. County  Maryland Harford	100	5 Yrs.  c. City, Town or Lo  Joppatowr			Aug.	31, 1941		OMA Inside City Limits 1 ☐ Yes 2 📆No
Maryland 21215-0036 d 2 should be filled within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than 'natural', or iteme 23e or 28e-f ehow traumatic event, the Medical Examinar must be notified at	Funeral Dire	10e. Street and Number  405 Avery Court  11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 SJYes 2 □ No If Yes, Give	in U.S. 13.	10f. Zip Code 21085  Was Decedent of His f Yes, specify Cuban	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American Ir k, White, etc.	
2121 ad within rgiene. er than	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)	Year or Dates:	16a. Deced (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired) Supervis	ion uring most of wor		16b. Kind of Bu	Whi siness/Industr ic Comp	ry
Maryland d 2 should be flightly and Mental Hy Z7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last)  Johnnie (nmn) Had  19a. Informant's Name/Relationship (T)	pe, Print)	1	ng Address (Street ar	Roseman	y (nmn)	er, City or Town,	State, Zip Cod	
t a ge i		Joan Harper / Wi.  20a. Method of Disposition  1	Removal from State	Ob. Place of Dispo	Avery Cour sition (Name of natory or other place Service Co	)	Date	Maryland 20c. Location - Towson	City or Town,	State
Baltimor permit. Pages · Depertment of t Important: If Its eny Injury or ot page.		21. Signature of Funeral Service Licens	90 <b>j</b>	22 <b>N</b>	Name and Address ICCOMAS Fu 1317 Cokes	of Facility ineral Ho bury Ro	ome, P. <i>R</i> ad, Abir	A. ngdon, Ma	aryland	
PV60,  All physician and physician and physician and physician and physician and the burial-transit physician and	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPTC  Due to (or as a co	SHOCK insequence of):	IRIES.	ERTIFICATION AP			Inte	avail Belween set and Death Day S
o. C. BOX 687, at the death certificate by the attending physicached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lached for use as the lack	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 30 9 □ Unknown	d	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery onth Day	y Year
= 00	ρ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giver	n in Part I.			3 Probably	
The lay	Be Completed	25. Was case referred to medical examiner?				26. Place of Dea	auto perfo 1 Tes	psy ormed? d 2000 1	orior to comple leath? Yes 2	etion of cause of
SION Of tending Phy leath. tor: After this the funeral d	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined.	28a. Date of Injury (Month, Day Ye. 07/06/200 28e. Place of Injury	6 21,27 At home, farm, str	28c. Injury Work? 0 M 1 🗆 Y	4   Nursing n	28d. Describe  7 oTOR  28f. Location	treet and Number	ed C <i>RASH</i>	ute_Number,
Hospl 4 hou Funer	edical Certi	29a. Certifier 1 Certifying Phy	building, etc. (S. STREET  sician: To the best of manner: Or the bast of exa	y knowledge, deatl	n occurred at the time	a, date and place	City or To CALVACY , and due to the	cause(s) and ma	nner as slated	LAIN Mal.
To the within 2 To the complet	Med	29b. Signature and trille of contribution	1.0.		29c. License 17643	number		29d. Date signed		Year)
Sta Registr		31. Date filed (Month, Day, Year)	ompleted cause of death OCK TRIVILL 32. Registrar's 8	9/22.	Print) SOUTH GA	EENE S	T. B	9LTTMBRE	E MD	21201

06-06665 Kyliah Johnson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certificate	of Death		Re	g No. 200	16 2880
Physici		Decedent's Name (First, Middle,	_				Date of Deat     Month	Day Year	3. Time of Death 2133 hrs
edical Exami	iner	rty I I all	A.		John	SON or Location of Death	Septembe	r 5, 2006 4c. County of Death	
		4a. Facility Name (if not institution, Good Samaritan Hospit	-		Baltimore			4c. County of Deatr	ı
Euporol				(In yrs. last birthday			s. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	tholace (State or
Funeral Director		213-59-5929	1 M 2 F	6	Yrs. Months Da		_	Foreig	
any		Usual Residence of Decedent  10a, State  10b, County	<u></u>	10c. City, Town or Le	ocation				10d. Inside City Limits
<u> </u>		MD N	Δ	Balti	more				1 X Yes 2 No
rylane a-f sł t onc	ctor	10e. Street and Number	•	24202	10f. Zip Code			ng. Citizen of What Cour	ntrv?
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	5629 Lothian	I tak beng	Δ		21212		U.S.A	
vith the s 23a		11. Marital Status	12. Was Decedent B		Was Decedent of F		pecify Yes or No-		ican Indian, Black,
eath v item	Funeral	1 X Never Married 2 Mar	ried Armed Forces?	No	If Yes, specify Cuba			White, etc.	
fter d I". or		3 Widowed 4 Divor	1 Yes 2X ced If Yes, Give Year or Dates:	1 No	Yes 2X N	lo specify:		Specify:	Black
72 hours after death with the Maryland n'natural", or items 23a or 28a-f she al Examiner must be notified at once	d by	15. Decedent's Education (Specif			edent's Usual Occup			16b. Kind of Business/l	ndustry
6 72 h an "n cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ig most of working in	e. Do Not ascici	1164)		
15-0036 filed within 1 Hygiene of other tha	эт	Kindergarter	na		Student	18.Mother's Name	/ <del>=</del> :	Schoo	1
filed Hyg Hyg od oth		17. Father's Name (First, Middle, L Kenard Johnso	· ·				Glover	naiden Surname)	
21215-0036 and be filed within 7 Mental Hygiene marked other than	o Be	19a Informant's Name/Relationshi	p (Type, Printh)	19b. Ma	ailing Address (Stre			ber, City or Town, State	. Zip Code)
Baltimore, MD 21215-0036 Departir Pages I and 2 should be filed within 72 hours after Department of Helant and Mental Hygiente Important: If item 77 is marked other than "natural". injury or other traumatic event, the <u>Medical Examiner</u>		Kenard & Mecc	a Johnson	56				, Balto,	
e, h L and Health item		20a. Method of Disposition			sposition (Name of corrother place)	emetery,	Date	20c. Location - City or	Town, State
nt: If		1 XXBurial 2 Cremation 4 Donation 5 Other Spe			emorial	Park 9/	14/06	Randalls	town, Md
Baltimore, permit Pages I ar Department of Hea Important: If ite		21. Signature of Funeral Service Li	censee		22. Name and Addre				
E Pe m	1	2 a. Part I. Enter the disease, or or	· Juank		4300 Wab	ash Ave	, Balt	imore, Md	21215
Physician		2 a. Part I. Enter the disease, or or failure. List only one cause or	omplications that caused to each line.	the death. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease or condition resulting in death)	a Seizure						Death
~ A	V		Due to (or as a conse	quence of):					
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):					
	Examiner	cause. Enter Underlying Cause	c. Due to (or as a conse	quence of):					
ecuted and transit		events resulting in death) Last	d.	4					
ਜ਼ ਜ਼ e	n/Medical	X UNPENDED	AMENDED ite	em#23a,27,pe	rME.0860. 10	0/12/06 TT	-		
760, ficate be ex g physician t the burial	Mec	IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d. Date of delivery	,
687 certification	ian/	23b. Was decedent pregnant in the past 12 months?	Live Dittil	2 time of death 5	1	Ectopic pregn	ancy	Month [	Day Year
Box 68 e death certi the attending	Physiciar	1 Yes 2 No 9 Unkn		time of death 5	Other (Specify)			31.00	
• 4 >4		Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause	e given in Part I	23e, Did to	bacco use contribute to	the cause of death?
P.O res that to signed by	d by						1 Yes	2 No 3 Prob	pably 4 Unknown
rds requi	lete	l					24a. Was a		topsy findings available completion of cause of
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should b	Completed			<del></del>			perfor	med? death?	
1 0 1	ပို	25. Was case referred to medical			26 Pla	ce of Death (Check			
Vita ysicia his ce direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 ER/Outpa	tient 3 DOA	Other Nursi	ng Home 5	Residence 6 Other	r.
of of mg Ph	Ë	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	ry 28b. Time	of Injury 28c. In	jury at Work?	28d Describe h	now injury occurred	
ion tendi eath. tor: A	랿	1 X Natural 5 Pendir 2 Accident Investi	ng		1_	Yes 2 No			
Division pital or Attendii ours after death. eral Director: A	iji	3 Suicide 6 Could	not be 28e. Place of Inj	ury - At home, farm,	street, factory, office	building, etc.	28f. Location (S or Town, S	Street and Number or Rutate)	ral Route Number, City
fire ou	Certification: To	4 Homicide determ	nined (Specify)						
4 4 0			vsician: To the best of my iner:On the basis of exam						
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated			nse number	at the time, gate	29d. Date signed (Mo.	
		70/ 0000	DYK 1			C.M.E.		September 6, 20	
		30. Name and address of person v	who completed cause of di	eath (Item 23a)					
			ssistant Medical Ex		Penn Street, Ba	altimore, MD 21	1201		
s	tate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	lance Mar				
Regis			BOG Margar	. It as	ORAGE				

			For Stata	State of Maryland /			lental Hygi	ene 2006	28805
	, a	*	Registrar  1. Decedent's Name (First, Middle, Last	ii)	Certificate of	Death	2. Date of Death	g. No.	3. Time of Death
	Physici /Medic		Valderia	Jone			Sept.	10,2006	0800
	Examin	er	4a. Facility Name (If not institution, give	Health + Rehah	Ctr. Bal	timore	,	4c. County of Death	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. last b	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year 92   Sirthpl	ace (State or Foreign
	v		Usual Residence of Decedent  10a. State 10b. County	10c City To	wn or Location		Sept. 21	1131300	Od. Inside City Limits
	Maryla a-f eho	tor	Maryland NIA	1 Ba	Itimore				1 Yes 2 No
	with the a or 28 be not	Funeral Director	10e. Street and Number	Ha Aug	10f. Zip Code	17	10	g. Citizen of What Count	try?
	eme 23	ineral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
22	72 hours alter death with the Maryland natural; or Iteme 23s or 28s-1 ehow dical Examination most be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 😿 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 □ Yes 2 No			Specify: RI	ick
5	n 72 ho "natura	Completed	15. Decedent's Ed (Specify only highest gra		Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing 1	6b. Kind of Business/Ind	ustry
717	filed within Hygiene. other than "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook			Loyola	College
	2 should be filed and Mental Hygi Ie marked other Burnatic event, I	To Be	17. Father's Name (First, Middle, Last)	inson		18. Mother's Name	e (First, Middle, M	aiden Silmame) + 0 o to r	
d y	2 should and Mer le marke aumatic	-	19a. Informant's Name/Relationship	1 - / /	9b. Mailing Address (Street	and Number or Run	al Route Number.	City or Town, State, Zip	Code)
ב ע	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Menial Hydjone. Deportment of Health and Menial Hydjone. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show eny Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and DEC.		1111, Vernon 1 20a. Method of Disposition	=Vans	of Disposition (Name of tery, crematory or other pla	Hgts. H	Je Bal	Oc. Location - City or Tox	wn, State
2	permit. Pages Depertment of Important: If it eny injury or o		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Met	TO Cremato	18/18/ VI	2006 7	Balto, IV	1d.
a	Depert Depert Import eny in		21. Sign ture of Funeral Service Licen	L. Russ	Joseph L	Sector A	uneral	Home, P.A.	
	- 4 F		ships, or heart fallure. List only	plical in ns that carried the death. Do one cause on each line.				st.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aEnd State  Due to (or as Fonsequence	The second secon	cial			
	Examiner	_	Sequentially list conditions,	b. Seulle /	+sevD				
	cuted nd ransit	Examine	l ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. severe pe	riphingo	Va	sculo	e disea	re
5	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as a conse uenc	ee of):				
100	The law requires that the death certificate ite has been signed by the attending phys page 2 should be detached for use as the	Medical	IF FEMALE:	. G.					
6	death ce s attend d for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		у		23d. Date of deliver Month	ry Day Year
5	w requires that the death certific been signed by the attending pl should be detached for use as t		9 Unknown  Part II. Other significant conditions of	9☐ Unknown	in the underlying cause or	ven in Part I	23e. Did toba	acco use contribute to the	e cause of death?
cords,	quires t an signe	ed by		Jimbaling to dodin out hat housing	g in the disconying educate gr	voit in t dit i.		s 2 □ No 3 □ Proba	
מי	e law re has bee je 2 sho	Completed					24a. Was an autopsy perform	prior to con	osy findings available appletion of cause of
אוומו	rsician: The law s certificate has b lirector, page 2 s	0	25. Was case referred to medical			26. Place of Deat	1 Yes 2	□No 1□Yes	2 No
5	Physical this ceral direction	To B	examiner? 1  Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ EP/0 28a. Date of Injury 28b	Outpatient 3 DOA Ott	her: 4 Nursing Ho	me 5 Resider	nce 6 Other (Specify	)
5	ath. or: After se funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wo	rk? ]Yes 2 No	200. Describe nov	winjury occurred	
2	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowled ninar: On the basis of examination a	lge, death occurred at the ti and/or investigation, in my (	ime, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29	d. Date signed (Month, E	Day, Year)
٨	4		▶ 18 4 Thed M	D	D	39127	)	9/11/20	06
7			30. Name and address of person who A AHMED M	D 82/ N 2	CILDINI ST	Ball	more	M1) 212	-0/
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 200	2. Registrar's Signature	poste				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician ARGARE 9000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 41/13 Birthplace (State or Foreign
 Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 25 F Yrs. 214-22-4541 Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County ? le marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Maxical Examiner overt by notified at 1 Yes 2 No Director Ovelless HBING-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number THE Kioy-AFT 3100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Slatus Black, White, etc. 1 Never Married 2 Married 5 0 ( 1 L 3 1215-0036 timbre, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 57AS VOLZELSAN IMPL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 le any Injury or other trau 31134 NEO L 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State ▲ Donation 5 Other (Specify) 21. Signature of Funeral Service License BES 4657 May 3 NEWPORT DRIVE FORST Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stroke Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or air a consequence of): burial-transit nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter d be detached for u in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown should b 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: Aft 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 Name and address of person who completed cause of death (Item 23a) (Type, Print) 206 m.D 31. Date filled (Month Day 2 2006 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - Stete Registrer		Certificate of Death	Reg. N	2006 28807
ш	Physici	an	1. Decedent's Name (First, Middle, Last	K JOHNSON	SR.		ay Year 6:15 PM
Ž.	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		c. County of Death
			BON SELOUR		BALTIMOZE  fav) If Under 1 Year   If Under 24 Hrs		
	Funeral Director		5. Social Security Number 6. Se 218–18–7332 15	7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth Month, Day, Year 10/03/25	9. Birthplace (State or Foreign Country) Baltimore City
	show	٥٢	10a. State 10b. County DC	10c. City, Town o Washin			10d. Inside City Limits Y Yes 2 □ No
	28a-f	rect	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Country?
	th with 23a or	ai Di	4313 - 12th Stree	et, N.E.	20017		US
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If them 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (G	ecedent's Usual Occupation live kind of work done during most of wo. 'e. DO NOT use retired) rtographic Technic	rking	S. Government
g	be filed tal Hygi d other event, i	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maide	n Sumame)
Maryland	should tind Ment	To	Leon Johnson	8.1		Peoples	
ā Z	and 2 st salth and n 27 is n isr traun		19a. Informant's Name/Relationship (T) Lawrence K. Johns		lailing Address (Street and Number or Ru Karen Blvd., Capo		
ore,	es 1 a of Hea if item or oths		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Di cemetery,	isposition (Name of crematory or other place)	Date 20c. L	ocation - City or Town, State
Baltimore,	t. Peges rtment of l rtant: if it		4 ☐ Donation 5 ☐ Other (Specify)	Lincol	n Memorial Cemeter  22. Name and Address of Facility F		land, Maryland
Ba	Dept.rtr Dept.rtr Impc.rts any nji		21. Signature of Funeral Service Lichts				, Washington, DC 200
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Aspivatio	on predu	ou's	Onset and Death
	Examiner			Due to (dr as a consequence of):	on prevn	mention	1 46011
	B 45 5	iner	cause. Enter Underlying	ue to (or as a consequence of):	5.44	Satur	10-09
_	al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to r s a consequence of):	Mou		
68760,	tificate be executed g physicien and as the burial-transit	Aedical	L.	Benen	anortatic +	typertr	oply
89 x	ertifica ding ph	/Med	IF FEMALE:	3c. If yes, outcome of pregnancy	ł _	L	
.О. Вох	es that the death cer igned by the attendir be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
o, D	ss that gned b	by Pi	Part II. Other significant conditions con	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w require been si should b					1 ☐ Yes 2	Probably 4√Unknown
Il Records,	The ia ste hes page 2	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy lindings available prior to completion of cause of death?  1 □ Yes 2 No
Division of Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	lospitat:	Other	ath (Check only one)	
o c	g Physics ter this neral di	$\vdash$	1 Yes 2 No 27. Manner of Peal	1 □ Inpatient 2 ► P/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	lome 5 Residence 28d. Describe how inju	
Sior	r Attending I er death. rector: After by the funer	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day 16a) Inju	M 1 Yes 2 No		
	P S S S S S S S S S S S S S S S S S S S	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Stat	
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, d ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	s) and manner as stated. It place, and due to the cause(s)
	Veithi To the	Σ	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
F	,		Wenness 30 Name 200	- Zull	DI5425	8/	25/06
	20		30. Name and address of person who co	empleted cause of death (Item 23a) (Ty)	pe, Print) 13 Coumany)a	after AV	cara SVILLE INTA
	Sta		31. Date filed (Month, Day,-Year)	32. Registrar's Signature			
	Registr		SEP 1 2 20		The state of the s		

ORIGINAL

amend item 21 par fb 8859 9-12-06 yt. 1 - For State Registrar 28808 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elsie Mae Fincham Knight Sept 11, 2006 5:00am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing Center Mt. Airy Carroll 8. Date of Birth (Month, Day, Year)
Apr. 22, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours 1□M 2□F Yrs. Director 215-22-8687 86 1920 VA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5643 Woodbine Road 21797 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give<sup>1</sup> Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) fited within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Importent: if item 27 is marked other that any julyry or other traumatic event, II at 2002. Domestic <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest J. Fincham Ella Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. June M. Horst (Daughter) 5807 Woodbine Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \$\overline{\mathbb{N}}\$ Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park 9/14/2006 `4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD PROPERTY OF THE PROPERTY OF TH 21. Signature of Funeral Service Licensee PA (Box 195) Brian L. Haight per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Urinary Tract Infection /Medical Due to (or as a consequence of) Examiner Dementia Senile yrs Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Aortic Stenosis yrs Due to (or as a consequence of): the attending physician Box 68760 certificate be Parkinson Physician/Medical yrs IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Hypokalemea, Irritable bowel syndrome Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Anemia, anxiety, osteporosis autopsy 1 Yes 2**X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending P
 24 hours after death.
 Funerel Director: After ti Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, M.D., 801 Toll House Ave., D-1, Frederick, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 2 2006 Registrar

		-	for State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artmer <i>tifica</i>	nt of H te of L	ealth an Death	nd Me	ntal Hy	giene Reg. No.	2008	5 28	809
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	/Medic Examin	er	4a. Facility Name (If not institution, g	ive street and num			4b. City	Town, or		Death		4c. 0	County of Dear	n DRE C	TTY or Foreign
ı	Funeral Director		243-54-1648 Usual Residence of Decedent	1⊠M 2□F	70	Yrs.	Months	Days		Min.	Date of Bir (Month, Da	y, Year) 1930	5 NORI	thplace (State buntry) TH CARC	OLINA_
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e, mar	is 1 and 2 should of Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship NELLIE KENNEDY /	(Type, Print) WIFE	205	1176	SAR	EANT			IMORE	, MD			
	permit. Peges 1 Department of H Important: If Its any injury or ott ance.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	city)	State	Place of Disponentery, creation	natory or L CEN	other plac IETER	Y Set Facility	EPT. 20	14, 006	ROOK	ation - City or		D
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8/60,	cate be executed physicien and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec										
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<u> </u>	ysician: Th is certificete director, peg	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	] ER/Outpatier	2M F	Oth Oth			Check only		☐Other (Spe	10.6c)	
Division of	Jing Ph After th funeral	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of (Montalion		28b. Time o Injury		28c. Injun Worl		28	d. Describe			iony)	
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	10		30. Name and a dress of person wh	o completed caus			Print)			*.				£	
	Sta Registi		SETAL PATEL  31. Date filed (Month, Day, Year)  SEP 1 2. 2006	300/ 32. R	egistrar's Sign	aturg	I EK	STRE	EIE	3111	TITIOR	E, '	11D Z	1225	

State of Maryland / Department of Health and Mental Hygienes o o

Certificate	e of Death	Re	2006 g. No.	2881
		2. Date of Death Month	Day Year	3. Time of Deat
	Town, or Location of Deat	SEPTEMBER	4c. County of Death	8:10 A
st birthday) If Under 1		8. Date of Birth (Month, Day, 4/15/	Year) 9. Birthp	lace (State or Fore try) uania
Town or Location				0d. Inside City Lim
Forest Hi				1 ☐ Yes 💹
10f. Zip (	21050		g. Citizen of What Cour USA	itry?
13. Was Deceded If Yes, special 1 Yes 2	ent of Hispanic Origin? (S ify Cuban, Mexican, Puer No Specify:	pecify Yes or No- to Rican, etc.)	14. Race · Americ Black, White, Specify: Whi	etc.
16a. Decedent's Usual (Give kind of work life. DO NDT use	k done during most of wo	rking	6b. Kind of Business/In	dustry
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ce of Disposition (Name	Harford H		VIIIE, MD Oc. Location · City or To	
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	Funeral (		800 Harfo arkville,	MD212
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		ath (Check only one		
	Bc. Injury at Work?	28d. Describe hov	ice 6 Other (Specify vinjury occurred	/)
M e, farm, street, factory,	1 ☐ Yes 2 ☐ No , office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
edge, death occurred a n and/or investigation,	at the time, date and place in my opinion, death occu	a, and due to the cau	use(s) and manner as si e and place, and due to	ated. the cause(s)
29c.	License number	296	d. Date signed (Month,	Day, Year)
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1	3a) (Type, Print)	3a) (Type, Print) L ROAD BEL AIR, MD.	つら2255 Sa) (Type, Print) L ROAD BEL AIR, MD. 21014	3a) (Type, Print) L ROAD BEL AIR, MD. 21014

238 "natural", or than

Baltimore, Maryland 21215-0036

10:00

2006

SEPTEMBER 11,

Box 68760. o Division of Vital Records, P.

DOROTHY KAHI

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 10:00 AM Dorothy Isabelle Kahl September 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 218-12-8513 88 21. Feb. 1918 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland | Harford Abingdon Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 Silver Spruce Lane 21009 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home s 1 and 2 should be filed v f Heelth and Mental Hygie ftem 27 is marked other t other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Charles Frederick Darney Dorothea Wilhelmina Diller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heelth ar
important: If item 27 is
any injury or other trau Catherine A. Keller / Daughter 2909 Silver Struce Lane, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns 9-13-06 Bel Air, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy 2X No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ٩ 1 ☐ Yes 2 X No 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2006

28811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528812 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Ashod Aram Krikorian September 1, 2006 1738 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 13, Birthplace (State or Foreign Country)
 Iraq **Funeral** Days Hours Year 1⊠M 2□F 579-42-1267 82 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mentel Hygiene.
and: If item 27 is marked other than "naturel; or items 23a or 28e-f show thy for other traumatic event, it is Medical Examine must be notified at ury or other traumatic event, it is Medical Examine must be notified at 1 ☐ Yes 2K No Directo Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16416 Montecrest Lane 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Manager Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Aram Krikorian Ovsanna Otrakjian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Krikorian/Son 16416 Montecrest Lane, Darnestown, Maryland, 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State September permit. Page Department Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 200621. Signature of Funeral Service Libensee Robert A. Pumphrey Funeral Home/Rockville, Inc., M01473 Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 23 Days /Medical Due to (or as a consequence of): Examiner Pneumonia Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner anding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Obstructive Lung Disease Unknown that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2X No 1 Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; After s after dea. 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel C 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Vicia J. Mistry me 9738 September 8, 2006 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Alicia T. Mistry, MD,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 28813 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician Betty Knight Sept. Jane 2006 10:00 A.M /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Carroll 6640 Woodbine Road Woodbine If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Deys Hours Min. 1 □ M 2 □ F Yrs. Director Dec. 11,1925Maryland 80 213-38-1441 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Woodbine Md. Carroll 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6640 Woodbine Road 21797 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Dept. of Commerce 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Welty ၉ Walter C. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21078 204 Ringneck Ct Havre DeGrace Md Knight son Eric Thomas 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Frontier 5 ☐ Other (Specify) Sept 13 Md Parklawn Mem. Park Rockville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2006 Burrier-Queen Funeral Home and Crematory 1212 West Old Liberty Road Winfield, MD nter the mode of dying, such as cardiac or respiratory arrest, Approximate Inter the disease, or complications that of used the death. Do not en or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CARDIO RESPIRATORY FAILURE ? MINUTES Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physician and for use as the bunel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No Ą 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? certificate has funeral director, page 2 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4□ Nursing Home 5 PResidence 6 □ Other (Specify) To 1 Yes 21 No this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural s after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only 29b. Signature and the of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) OHN SUZMED 6 MO 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SEP 1 2 2006

32 Registrar's Signature

			1 - For State Registrar		State of	Maryla	nd / Dep <i>Ce</i>	artment of F rtificate of	lealth <i>Death</i>	and M	lental Hy	giene Reg. No	2006	28815
	Physici /Medio		1. Decedent's Name Theodore	(First, Middle, Las Lacott	·						2. Date of De Month SEP	aath 11°,	2006	3. Time of Death 9:24 A M
ř	Examir		4a. Facility Name (# 2812 O1c	not institution, give I Joppa R		ber)		4b. City, Town, of Joppa	r Location	of Death			County of Death	
	Funeral Director		5. Social Security No. 220–42–84	441 1	ex ₹M 2□F	7. Age (In yrs	. last birthday Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir Month Da APR 1,	rth 192	9. Birth Cou Mary	place (State or Foreign intry) y Land
	ehow	č	Usual Residence of 10a. State	10b. County			ity, Town or L	ocation						10d. Inside City Limits 1 ☐ Yes 2 ∏ No
	death with the Maryland ms 23a or 28a-f ehow rmust be rediffed at	Funeral Director	MD 10e. Street and Nun 2812 Old		 ad	J.	oppa	10f. Zip Code 21085				10g. Ci	itizen of What Cou	
320		by Funera	11. Marital Status  1 Never Marrie 3 Widowed	ed 2 <b>X</b> Married 4 □ Divorced	12. Was Dece Armed For 1 1 Yes If Yes, Give Year or Da	dent Ever in loss? 2 \sum No tes: 69-7		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Or an, Mexica Specify	n, Puerto	ocify Yes or No Rican, etc.)	)-	14. Race - Ameri Black, White	, etc.
1213-0036	filed within 72 hours after Hygiene. Ither then "naturel", or ite ent, the Medical Examine	Completed	(Speci	15. Decedent's Ecify only highest grandary (0-12)	lucation		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	durina moi	st of worki	ng		Kind of Business/Ir	
ylang z	2 should be filed vand Mental Hygie and Mental Hygie is marked other is aumatic event, It	To Be Co	17. Father's Name (				Oaipe	SILCEL			(First, Middle Daley			
e, mary	l and 2 sho lealth and h om 27 is ma her trauma		19a. Informant's Na Rita Laco	otti/Wife		200	2812	ng Address (Street  Old Joppa  osition (Name of		Joppa	a, MD 2	1085	5	
Saltimor	it. Page ritment o ritent: if njury or		20a. Method of Disp 1 ☐ Burial 2 ≸ 4 ☐ Donation 21. Signature of Fur	Cremation 3 C	<i>(</i> )	Me Me	cometery, cre tro Cre	ematory or other place	Inc	9/12		Balt		
Ö	Dermi Depa impo any ii		) C	Lasting.	2. 100	ld Dri	29	emation 9 Freder	<u>ick R</u>	d Bal	ltimore	, MI	Inc.	Approximate
0,007	Create be executed hysician and physician and street and street street and street street and street	edicai Examiner	23a. Part1. Enter the shock, or hear Immediate Cause (idisease or condition resulting in death)  Sequentially list coning and the shock of the shock	Final n inditions, mediate rhying njury	a. Due to (c	or as a conse	quence of):	ans	M	ul	tife	ni	re	Interval Between Onset and Death
O. DOX O	Physician: The law requires that the death certific this certificete has been signed by the attending p ral director, page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent in the past 12 if yes 2 from 9 Unknown	months?		th 2 ☐ Fet nt at time of	aldeath 3[	Ectopic pregnancy Other (specify)					23d. Date ol deliv Month	ery Day Year
Olds, T.	en signed by	by	Part II. Other signifi	cant conditions of	ontributing to dea	ath but not re	sulting in the u	nderlying cause giv	en in Part I	l.			use contribute to t	the cause of death?
	n: The law r licete has be r, page 2 sh	Completed									1 ☐ Yes	osy ormed? 2 No	prior to co death?	opsy findings available impletion of cause of
	hysicia this certi al directo	To Be	25. Was case referrence examiner?	√o.			] ER/Outpatier		er: 4□Ni	ursing Hon		dence	6 ☐ Other (Special	<i>fy</i> )
NSION N	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide	5 Pending investigation 6 Could not be determined	28e. Place o	, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ☐	No	28d. Describe I	Street an	nd Number or Rur	al Route Number,
5	sspital or hours afte ineral Dia y filled in		29a. Certifier	Certifying Ph	vsician: To the t	est of my kn	owledge, deat	h occurred at the tin	ne, date ar	nd place, a	and due to the	cause/s	) and manner as s	stated.
	o the Ho nthin 24 o the Fu ompletel	Medical	(Check only one) 29b. Signature and	20 Metarcal Exam	and manne	sis of examin	ation and/or in	vestigation, in my o	pinion, dea	ath occurre	ed at the time,	date and	d place, and due to te signed (Month,	o the cause(s)
	->+ō		30. Name and address	Jan Jan	completed cause	of death (I'm	m 23a) (Tuna	DOC	47	65	8	•	9/11/0	)6
	6		Kiumarce	e Kashi,	M.D. 12	32 Rac	e Rd Si	iite 202	Balti	more	, MD 21	236	1	
	Sta Registr		31. Date filed (Monti	h, Day, Year) P 1 2 200	150	gistrar's Sign	ature	ale						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Stata Registrar	State of Ma	ryland / D	Certificate of	Death	Ra	g. No. 200	6 28818
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	
	/Medic	al	Constance Mae Lear  4a. Facility Name (If not institution, give s			4b City Town o	Location of Death	Septembe	4c. County of De	
	Examin	er	Gilchrist Hospice				WSON			timore
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birtl	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign
	Director		213-16-5106	M 2∭ F	84 Y	rs. Months Days	Hours Min.	July 25	1922 M	laryland
and	* =		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mary	if sho	tor	MD Balti	more		Parkville				1 Tes 2 No
th the	a not	lrec	10e. Street and Number	more		10f. Zip Code		1(	g. Citizen of What C	country?
th wi	23a (	Funeral Director	1809 Wycliffe Road				234		United St	ates
er dea	iteme Dar m	nue		2. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
U K I K I J-0000 filed within 72 hours after death with the Maryland	Man.	by F	1 ☐ Never Married 2 ☐ Married  3 Æ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates:	0	1 ☐ Yes X No	Specify:		Specify: W	Mhite
2 hou	naturi lical E	ted	15. Decedent's Educ (Specify only highest grade	ation	16a.	Decedent's Usual Occup (Give kind of work done of	ation	200	6b. Kind of Busines	s/Industry
ithin it	han 1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		life. DO NOT use retired	0	,,,,		
led v	Hygiel rt, rt		12 17. Father's Name (First, Middle, Last)			Homemaker	18. Mother's Nam	e (First Middle M	Own H	lome
d be f	c eve	o Be	George Hughes					ne Hart	aluen Sumame)	
shoul	mari umati	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)	19b.	Mailing Address (Street			City or Town, State,	Zip Code)
and 2	alth a n 27 is er tre		Fran Trojanowski -	Daughter	51	0 Cedarwood	Ct., Bel	LAir, MD	21014	
Pages 1	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show Important: If Item 27 is marked event, the Madical Examinat must be notified at an		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	West A	Disposition (Name of crematory or other place rundel cremator	у 9 <b>-</b> 11		oc. Location - City o	,
permit.	Departri Importa any inju pnce.		21. Signature of Funeral Service License	3		22. Name and Addres	ss of Facility Amb	orose Fur	neral Home	, Inc.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused to	the death. Do n	ot enter the mode of dying	NGS Fry I g, such as cardiac	d., Lans or respiratory arre	sciowne, ML st.	Approximate Interval Between
Ph	ysician		Immediate Cause (Finat disease or condition			ion Den	entin			Onset and Death
	Medical aminer		resulting in death)		consequence o					- 8
pe	は 質	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	1).				
, execut	ng physicien and as as the burial-transit	Exan	that initiated events c. resulting in death) Last	Due to (or as a	consequence o	f):				-
te be	ysicie se bur	edical	d							
rtifica	ing ph as th		IF FEMALE:							j .
be death ce	been signed by the attendin should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
thet t	ed by detac		Part II. Other significant conditions conf	ributing to death but	t not resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
quires	n sigr uld be	ed by	Seizules,	Atrial to	brill	atin		1 ☐ Ye	s 2 □ No 3 🔀 F	robably 4 Unknown
a v e	2 sho	plet						24a. Was an		utopsy findings available completion of cause of
The	page	Completed			-			perform 1 Yes 2	ed? death?	s 2 No
cian:	ertific ector,	Be (	25. Was case referred to medical examiner?	ospital:		100		h (Check only one	4	
ding Physi	within £4 hours after deam.  To the Funeral Director: After this certificate has been signed by the attending physicien and \$\frac{1}{2}\$. To the Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	tlon: To	1 Yes 2 No Common No. 1 Yes 2 No Common No. 27. Manner of Death 1 No. 1	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. T	jury War	4   Norsing Ho	ome 5 Resider 28d. Describe hor	nce 6 Other (Sp w injury occurred	ecity) Hospia
al or Atten	affer deal	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, far (Specify)	m, street, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
• Hospita	24 hours e Funera letely fille	Medical C	29a. Certifier 1 Tertifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner state	examination and	death occurred at the tin Vor investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier	1 2		29c. Licens			d. Date signed (Mor	
	/		1 / Knthu	, Mily	On,	シン	5 205	S	estent	-6,2006
	6		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (	Type, Print)	Baltin	we Vi	ND. 21	-6, 2006 204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 200	32 Registra	's Signature	Gorle				

			1- State of Maryland / Department	artment of Health and M rtificate of Death		giene 2008	5 28817
	Physic		1. Decedent's Name (First, Middle, Last)  Rosalina Lim		2. Date of Deal Month	Day Year	3. Time of Death 4:30 P.M
F	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Sept.	8 2006 4c. County of Deat	
			Gilchrist Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	TOWSON	8. Date of Birth	Baltimore	
b	Funeral Director		215-70-4596 1□ M 2\ F 94 Yrs.	Months Days Hours Min.	(Month, Day, April 7	, Year) Co	hplace (State or Foreign untry) a , Peru
	ow ==		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ocation			10d. Inside City Limits
	e Mary	ctor	Maryland Baltimore County Perry Hal	1			1 ☐ Yes 2 🛣 No
	h with th	ai Dire	10e. Street and Number 9404 Belair Road	10f. Zip Code 21236		og. Citizen of What Co Inited State	•
036	permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hygiena Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinant must be inclified at ance.	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※☐No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Ch	e, etc.
1215-0	within 72 ho ana. than "natur te Medical.	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Sh Teacher	ing	16b. Kind of Business/ Elementary Schools	
Maryland 21215-0036	uld be filad Aental Hygie rked other tic event,	To Be Co	17. Father's Name (First, Middle, Last) Kwan Leung Tang	18. Mother's Name Unknown			
, Mary	and 2 sho salth and N n 27 ie ma er trauma			ng Address (Street and Number or Run Vy Hill Road Hunt			
altimore,	Pages 1: nent of He nnt: If Iten ury or oth		1 Aburial 2   Cremation 3   Hemoval from State	matory or other place)	16,2006	20c. Location - City or Timonium	Town, State , Maryland
Balt	permit. Departr Importe any Inju		21. Signature of Funeral Service Licensee	Name and Address of Facility aceful Alternative 25 York Road, Time	es Funer onium MA	al&Cremation	on Ctr. P.A.
	Physician		23a. Part T. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. Usy only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac of		est,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to for as a consequence of):				
	utad d anslt	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
8760,	cate be executad physicien and the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequence of):  d.				
O. Box 68	ath certifi ttending or usa as	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	quiras that the de en signed by the a ruld be datached f	þ	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to	the cause of death?
Vital Records,		Completed			24a. Was an autops perform	y prior to d ned? death?	topsy findings available ompletion of cause of 2 \square No
	Physician: Th r this certificate ral diractor, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatier	26. Place of Death		ence 6 Other (Spec	Who have a said
Division of	Jing After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury			ow injury occurred	1105/12
<u>N</u>	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town		
	e Hosp 124 bou e Fune detely fil	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, deatl (Check only one)  1 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
)	To the within To the comp	Ň	29b. Signature and title of certifier  30. Name and address of person who completed cau death (Item 23a) (Type.  A A C-y C-bMC 670 ( 31. Date filed (Month, Day, Year) 2 2006  32. Hististrar's Signature.	29c. License number D25205	29	9d. Date signed (Month	, Day, Year) _ 8, 2006
	A		30. Name and address of person who completed cau death (Item 23a) (Type,	N. Charles St.	Balt	s. rud De	205
	Sta Registr	te ·	31. Date filed (Month, Day, Year) 2 2006 32. Hististrar's Signature.	barle			

06-06569 Sandra Lake Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 28818 Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death **Medical Examiner** Sandra Lee Lake 0808 hrs September 2, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 201 Patapsco Avenue Dundalk **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Director 212**-**78-1818 07-16-1959 47 M 2X X Usual Residence of Decedent 10a. State 10c. City, Town or Location any 10d. Inside City Limits MD Baltimore or items 23a or 28a-f show must be notified at once, 1XXYes 2 No death with the Maryland Director 10e. Street and Number 201 Patapsco Ave 10f. Zip Code 10g. Citizen of What Country 21222 USA 11. Marital Status

1 X X
Never Married Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 2 Married Armed Forces' White etc. Yes "natural", or 3 Widowed 4 Divorced If Yes. Give Year 1 Yes 2XX No specify: Specify White à Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours a
Department of Health and Mental Rygiene
Important: If item 27 is marked other than "natura
injury or other tranmarite event, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Flagger Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gilbert Earl Lake Theresa Agnes Smith 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ Susan Gephardt/sister 2532 Joppa Rd. York PA 17403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 XXCremation 3 crematory or other place) Removal from State Chesapeake Crematory 9/12/05 Beltsville, MD Donation 5 Other Specify 21 Signature of Funeral Service License 22. Name and Address of Facility CAFA 8717 Greenpastures Dr. Baltimore MD 21246 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Narcotic (morphine and oxycodone) intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED item#23a.27.28a-f.perME.g859.9/15/06 TT certificate be Division of Vital Records, P.O. Box 68760 attending phys or use as the bi IF FFMALE 23c. If yes, outcome of pregnance 23d Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Dither (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Vinknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No Director: 5 Pending the Fnd 9/2/2006 Fnd 8:00 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 201 Patapsco Avenue (Specify) found in residence Homicide Raltimorn, MD 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) O.C.M.E. September 3, 2006 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year State 32. Registrar's Signature SEP Marie 5 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	_	giene Reg. No.	200	6 2	28819
	Physici	an	1. Decedent's Name (First, N								2. Date of De Month	ath Day	7 Y	3.	Time of Death
	/Medic	cal	Andrew Will  4a. Facility Name (If not instit	iam Lucot Jr			4b. City, To	um or l	conting o	of Dooth		10.6	County of E	00	, TO PM
	Examir	ner	5. Social Security Number	s care	en +	er ast hirthday)	Hav If Under 1	R 1	If Under:	Orac	e, ma	t	tar-	torc	(State or Foreign
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	p >		Usual Residence of Deceden		10a Cib	, Town or Lo									
	shov	5					cation								nside City Limits ☐ Yes 2X No
	28a-1	Director	Maryland Har	ford	Aber	rdeen	10f. Zip C	ode				10g Citiz	en of Wha	it Country?	
	3a or	=	822 Lynn Lee	Drive			210					USA			
	death	Funeral	11. Marital Status	12. Was Decede		S. 13.		nt of His	panic Orig	gin? (Spe	cify Yes or No			American In	dian,
98	or Ite	y Fu	1 Never Married 2 🛣	Married 1 XYes 2 If Yes, Give	□ No		il Tes, specili 1 □ Yes 🏋		Specify:	i, Fuerto i	nican, etc.)		Specify:	White, etc.	
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Evarilise must be rediffed at	ed by	3 Widowed 4 Divo	rced Year or Date	os:		dent's Usual						V	white	
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21215-0036	filed within Hygiene. Ithar than "	Completed	Elementary/Secondary (0-	12) College (1-4 2	or 5+)	Prop	rietor					Dry	Clear	ning/I	Laundry
nd	be filed ntal Hygi nd other evant, I	Be	17. Father's Name (First, Mid								(First, Middle,		Sumame)		
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. itam 27 is markad other than "netural", or items 23a or 28a-f show other traumatic evant, the Medical Examiner must be retified at		19a. Informant's Name/Relat				-				i Route Numbl erdeen				· .
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altimore,	0 0		1 🔀 Burial 2 □ Cremat `4 □ Donation 5 □ Othe	ion 3 □Removal from Sta er (Specify)	119		natory or other Luther		· 1	-11-	06	Joppa	. Mai	ryland	i
alti	permit. Pag Department Important; I any injury o		21. Signatura J Funeral Sen	vice Licensee	/						me, P.			4	
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E			23a. Parti. Enter the disease shock, or heart failure.	e, or complications that cau List only one cause on	sed the death h line.	. Do not ent	er the mode	of dying,	such as	cardiac o	r respiratory a	rrest,		Inter	roximate rval Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	CINEN	111									
	Examiner			Due to (or	ALLEANT	ience of):									
	التبعيد	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	consequ	ence of):									
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	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	I LIVE DIN	n 2 ∏ Fetal t at time of de		]Ectopic preg ] Other (spec						Month	Day	Year
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a		e Co	OF Man ages referred to me								1 Yes	2 No	1 🗆		No
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J of	ding Phy h. After thi funeral o	n: T	27. Mann of Death	28a. Date of		28b. Time of Injury		. Injury a			8d. Describe I			эроску	
Sio	Attanding r death. actor: After by the fune	atic	E C / tooldorit	restigation		,,	М		es 2 🗆 N	Vo					
Division		Certification;		termined 28e. Place of building	Injury - At ho etc. (Specify	me, farm, str	eet, factory, o	office		2	8f. Location (5 City or Tox	Street and vn, State)	Number o	r Rural Rou	te Number,
	e Hospital or 24 hours afte a Funaral Dir letely filled in b		29a. Certifier 1 Cert	ifying Physician: To the be	st of my knov	viedge, death	occurred at	the time	, date and	d place, a	nd due to the	cause(s) a	nd manne	r as stated	
•	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	edical	(Check only 2 Med	ical Examiner: On the basi and manner	s of examinati	ion and/or in	vestigation, in	my opii	nion, deat	h occurre	d at the time,	date and p	lace, and	due to the c	cause(s)
	To the within 2 To tha complet	M	29b. Signature and title of ce	rtifier C	0		29c. L	icense	number			29d. Date	signed (M	onth, Day,	Year)
•	, 1		P 41 34	5m	/-			174	041				171	V6	
1	214		30. Name and address of per	son who completed cause	of death (Item	23a) (Type,	1	Mn.	6 M	Mn	707	8			
	Sta	te	31. Date filed (Month, Day, Y	// 32. Reg	istrar's Signat	IA A	· (	, .,,	-		1- /	v			
	Registr		SEP	1 2 2008	Parties a	12	donelle	R							

State of Maryland / Department of Health and Mental Hygiene 2006 28820 1- For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Samantha Laffey 0140 M replembe 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Hours Yrs. None September 1, 2006 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23s or 28s-f ehow the Medical Examiner roust be notified at 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Funeral Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13828 Lullaby Road 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ۵ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 ie marked ot Lisa Canfield William J. Laffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra William J. Laffey / Father 13828 Lullaby Road, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State September \* 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Inc. 8, 2006 Bethesda, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Overwhelming sepsis 8hrs /Medical Due to (or as a consequence of): **Examiner** Shis chongamnionins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Kespiratan distras syndome, hypeplashe lung, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? anasarca preumothurx, metabahe acidosis 24a. Was an autopsy performed? 1 Yes 2 No Thombocutonina
25. Was case ref-rred to medical examiner? 1 ☐ Yes 2 ☐ No Division of Vital MOOHISIM animia. Hospital or Attending Physician: 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier D50902 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Kimberly Iabolla, 9901 Medical Center Drive mo 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State 2 SEP 1 Registrar

			For State Registrar	State of Maryl		artment of H			ene . No 2006	28821
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Dav Year	3. Time of Death
	/Medic	al	Steven Mark Lewi  4a. Facility Name (If not institution, give:			4h City Town or	Location of Death	09	-07-06 4c. County of Death	943AM
4	Examir	er	Carroll Hospital			Westmin			Carroll	
	Funeral		5. Social Security Number 6. Security Number	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign ntry)
	Director		213-70-5251 Usual Residence of Decedent	43	115.			Feb. 28,	1963   Mary	yland
	anylan	_	10a. State 10b. County	10c	. City, Town or Lo	calion				10d. Inside City Limits
	the Mi	Director	MD Carroll  10e, Street and Number	1	New Winds	SOT 10f. Zip Code		100	. Citizen of What Cou	1 ☐ Yes 21 No
	3a or	I D	3306 Hooper Road			21776			ited State	
	death	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13. V		spanic Origin? (Spe n, Mexican, Puerto		14. Race - Ameri	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mential Hygiene. Item 27 is marked other then "naturel", or iteme 23a or 28a-1 show other traumatic event, its Medical Examination in the inclined at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		Yes 25 No	Specify:	rican, etc.,	Specify: White,	ite
21215-0036	2 hour		15. Decedent's Edu	cation	16a. Deced	lent's Usual Occupa		16	b. Kind ol Business/Ir	
215	within 7: ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	furing most of workii )	ng		
121	fled with the there is the the the the the the the the the the		17. Father's Name (First, Middle, Last)		Equip	oment Ope	rator 18. Mother's Name		oward Coun	ty Gov't
Maryland	id be f ental F ked of	To Be	Robert Ravell Lev	iat <b>i</b> s				Ann Borgi	,	
ary	2 should and Mis mari	-	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street a			City or Town, State, Zip	Code)
	and 2 lealth m 27 i		Lisa D. Lewis	100			oad New			
altimore,	Pages 1 nent of H int: if ite iry or oti		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ R			sition (Name of natory or other place	Joope	. 9,	c. Location - City or T	
altin	그 문학급 .	- 3	4 ☐ Ponalion 5 ☐ Other (Specify)  21. Signature ☐ File rat Service (Acense			anch Cem. Name and Addres	2006 s of Facility	11111	estminster ° C	
ă	Depa impo any ic		y aury of	anny		111 W. 01	een funer d Liberty	Road W	& Cremator infield, M	y, 21784
		V 1	a. Part1. Enter the disease, or complishock, r heart failure. List only or	ne cause on each if e.						Approximate Interval Between Onset and Death
	Physician / /Medical		immediate yause (Final disease or condition resulting in death)	HEPA"		NCE PE	IALOPA	4 cary		Olisat and Dagin
	Examiner			Due to (or as a con		CIRR	HOS15			
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V.	and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
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89	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Medical	IF FEMALE.							
Вох	eath certific attending pl	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1☐Live birth 2☐F	Fetal déath 3□	Ectopic pregnancy			23d. Date of deliver	ery Day Year
		ysic	1 Yes 2 No 9 Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)				,
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions con	ntributing to death but nol	resulling in the un	iderlying cause give	n in Part I.	23e. Did Jobac	cco use contribute to t	he cause of death?
ord	w require been sig should b	ted						1 Tes	2 No 3 □ Prot	pably 4 □Unknown
3ec	e law has b	Completed						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
tal	nn: The ficate ha	e Co	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2		2 🗆 No
Ţ	Physicien: this certificatal director.	To B	examiner?	lospital: 1X Inpatient	2 ER/Outpatient	3 DOA Othe			e 6 ☐Other (Specif	(y)
Division of Vital Records,	ing Ph		27. Manner of seath  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how		
isio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm stre		es 2 □No	28f Location (Stree	et and Number or Rura	I Pauto Number
<u>S</u>	et or A s after ii Dire ed in b	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	on, ractory, omoc		City or Town, S	State)	D / Todio / Talliber,
	To the Hospitel or Attending Physicien: The within 24 hours after death, To the Funeral Director; After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one) 12 Medical Exemin	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	- 10		29c. License			Date signed (Month,	
•			Donn	~ cc			30263		09-07-0	
	(n		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type, I	C.AVENUE	E, WEST	MINSTER	MD 21	157
200	Sta	A	31. Date lited (Month, Day, Year)	32. Redistrar's S	- Charles and the same of the	A .		•		
	Registr	ar .	SED 1 C 30	U5 Marie	H. A	ocalle 1				

DHMH 17 Rev 1/2001

ORIGINAL

				Maryland / Depa	artment of Health and rtificate of Death		ne 2006	5 28822
	Physic /Medi ) Examil	cal	Decedent's Name (First, Middle, Last)     CLARA     4a. Facility Name (If not institution, give street and numb		LEVI  4b City, Town, or Location of De	2. Date of Death Month SEP TEMBER	Day Year S 2006 4c. County of Death	3. Time of Death
	Funeral Director		Sinai Hontal of Baltimor  5. Social Security Number  215-52-2135  Usual Residence of Decedent	Q Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year If Under 24 F Months Days Hours M	8. Date of Birth (Month, Day, Ye 03/18/192	9. Birth Cou	N/A  nplace (State or Foreign unitry) EGYPT
CLARA	th with the Maryland 23a or 28a-f show	ector	MD BALTIMORE  10e. Street and Number	10c. City, Town or Lo	MORE			10d. Inside City Limits 1 ☐ Yes 2 No
J	ath with I	rai Dir	6930 MARSUE DRIVE APT. 2		10f. Zip Code 21215		U.S.A.	
LEVI,	Datuffice, Maryiaffid A.I.A.I.S-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itams 23a or 28a-1 show any lollury or other traumatic event, Ita Madical Examinar must be notified at ance.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	No es:	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu  □ Yes 2 No Specify:		14. Race - Amer Black, White Specify:	
3	AIAID-	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5+)  16a. Deced (Give Iife. E	tent's Usual Occupation kind of work done during most of v OO NOT use retired) TRESS	working 16b	CLOTHING	•
known	Mar yiarla d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	To Be (	17. Father's Name (First, Middle, Last) SHABTAI	MESI	HULAM ESTHE	łame <i>(First, Middle, M</i> aid ER		COSER
\$	and 2 sho salth and n 27 is my		19a. Informant's Name/Relationship (Type, Print) CHARLES LEVI / HUSBAND	6930 M	ng Address <i>(Street and Number or</i> IARSUE DRIVE APT	Rural Route Number, Cit. • 2-A - BAL	ty or Town, State, Zi TIMORE, M	р Соde) D 21215
Patrent	Pages 1 Iment of He Iment: If Item Jury or oth		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	""βETH TFILO	, ,	08/2006 WO	ODLAWN, MI	D
9 g	Deparit Import		21. Signature of Euneral Service Licensee	8!	. Name and Address of Facility S 900 REISTERSTOWN	SOL LEVINSON N ROAD - PIK	& BROS., (ESVILLE,	, INC. MD 21208
092	Physician /Medical Examiner pe prugician and prugician sud	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):	er the mode of dying, such as card	iac or respiratory arrest,		Approximate Interval Between Onset and Peath 45 days
Division of Vital Becords D O Box 68		Physician/Medi		ı 2 ∏ Fetal déath 3 ∏ tat time of death 5 ∏	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
0	quires that the signed by uld be detact	þ	Part II. Dither significant conditions contributing to deat	but not resulting in the un	nderlying cause given in Part I. Hyperterman		co use contribute to t	
Poog I	The law requir	Completed	Christic Renal Inselieur	x, Crypton	genic Curtosi	24a. Was an autopsy performed'	? death?	opsy findings available ompletion of cause of
Y VIII	Physician: The this certificate ral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho spital: 1 Input		3 DOA Other: 4 Nursing	eath <i>Check only one</i> Home 5 Residence	6 □Other (Speci	fy)
i do	ittending P death. stor: After I	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	njury 28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	llury occurred	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined 25e. Place of building,	Injury - At home, farm, stre etc. (Specify)		28f. Location (Street City or Town, St	ate)	
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the beside and manner	s of examination and/or invi	estigation, in my opinion, death oc	curred at the time, date a	and place, and due to	o the cause(s)
	Viit To con	2	29b. Signature and title of certifier	MO	RES - 00 C		Pate signed (Month,	Day, Year)
	1		30. Name and address of person who completed cause of MANISH ARORA MD	SINAI HOSPI	TTAL OF BALT	IMORE.		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Red	strar's Signature	and a			

		•	For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment o <i>rtificate</i>	of Health an of Death	nd Mei	ntal Hygie Reg	ene 2006	28823
I	Physici /Medic		1. Decedent's Name (First, Middle, La Annette	Leven	son				Date of Death Month	Day Year	
*	Examir	er	4a. Facility Name (If not institution, giv BRIGHTWOOD GARDE	NS		LUTHE	wn, or Location of DERVILLE			4c. County of Dea	ORE
14. V *	Funeral Director		5. Social Security Number 216-28-4914  Usual Residence of Decedent	ו או מודר	yrs. last birthday, Yrs.	Months D		Min.	Date of Birth (Month, Day, Y 8/05/19)	9. Bir Co 25	thplace (State or Foreign buntry)
	Maryland -f ehow lied et	tor	10a. State 10b. County	IMORE	c. City, Town or L BALTIM						10d. Inside City Limits 1 Tyes 2X No
	n with the 3a or 28a	Funeral Director	10e. Street and Number 600 CLIVEDEN ROA	D		10f. Zip Co			10g	U.S.A.	puntry?
036	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f ehow digal Evant, parmust te notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, GiveX Year or Dates:	in U.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2X	t of Hispanic Origin Cuban, Mexican, F No Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
21215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other then "naturel", or iteme 23s or 28s-f show event, I'm Medical Evantiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)		(Give	DO NOT use i	done durina most o	of working	16	OWN HOME	Industry
Maryland ;		To Be C	17. Father's Name (First, Middle, Last, HARRY	)	HERSH		18. Mother's	,	irst, Middle, Ma	iden Sumame)	_EVIN
	nd 2 state are trau		19a. Informant's Name/Relationship ( MAX LEVENSON / HU							City or Town, State, MD 21208	Zip Code)
altimore,			20a. Method of Disposition  1 Durial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	Ob. Place of Disp cemetery, cre ETH EL M	matory or othe	r place)	Date 9/10/		c. Location - City or RANDALLST(	
Ball	bed permit. Page My/Watthern to Department of Important: If Important: If Important: If Important of Importan	niner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	plications that caused the	death. Do not en	900 REI				N & BROS.	
. Box 68/60,	death certificate be executed e attending physicien and ed for use as the burial-transit	Physician/Medical Examin	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 2 7 No	c. Due to (or as a cold. d. 23c. If yes, outcome of print time and the second of the s	regnancy  Fetal death 3 (	⊒Ectopic pregi				23d. Date of de Month	livery Day Year
IS, P.O.	law requires that the de as been signed by the a 2 should be detached t	Ď	9 Unknown  Part II. Other significant conditions		ot resulting in the u	inderlying caus	se given in Part I.				the cause of death?
al Records,	The ete h	Completed							24a. Was an autopsy performe	24b. Were as prior to death?	utopsy findings available completion of cause of
or Vital	Physicien: Th r this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 🗝 6		2 ER/Outpatie		Other: 4 Nursi	ing Home		ce 6 □Other (Spe	cify)
	Q 0 0	Certification:	27. Manner of Death  Natural 5 Pending 2 Accident investigation		ar) 28b. Time o	of 28c.	Injury at Work? 1 Yes 2 No	ĺ	1. Describe how	injury occurred	
ž O	To the Hospitel or Attendir within 24 hours after death.  To the Funerel Director: At completely filled in by the fun		3 Suicide 6 Could not be determined	building, etc. (S	pecify)				City or Town,	,	
	the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier 4 Cartifying Pl (Check only one) 2 Madical Example (Check only one)	nysician: To the best of my minar: On the basis of exa and manner stated.	y knowledge, dea ımination and/or ır	ivestigation, in	my opinion, death	place, and occurred	at the time, date	and place, and due	o to the cause(s)
)	With Com	2	29b. Signature and title of certifier	< MO			icense number	$\Omega$		Date signed (Mont	
	le 1		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	20000	No.	201	9-07-00 Suite ND 2	110
100000	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's S		Road	C	2000	nbie	NOZ	1045

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Ruth Elizabeth Miner 9:40 PM September 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6928 Myersview Drive Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 3, 1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-60-1732 1 ☐ M 2 😿 F 53 Baltimore, MD Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow or other treumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 6928 Myersview Drive "naturel", or items 23a 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or item eny injury or other treumatic event. Le Madical Exemina-1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Driver School Bus County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David E. Freyman Helen L. Drury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Miner Sr. - Husband 6928 Myersview Drive Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 09-09-2006 Towson, Maryland 4 Dongtion 5 Other (Specify) 21. Signal refor Fungral Service Lines Charles F. Miner 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Meta Static Small cancer 3 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo the detached 9□ Unknown 9 Unknown been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed? certificate 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Q No 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Watural To the needs after death, within 24 hours after death.

To the Funerel Director: After the funerel by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier asallam M.D 45530 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) asa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2006 234/2 Registrar

			1 - For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene 2	006	28825
			Decedent's Name (First, Middle, Last	)							2. Date of De	ath		3. Time of Death
ı	Physici /Medi		Jeanette	Marie		Morel	and				Month Sept.	Day	Year 2006	1:04P M
	Examir		4a. Fecility Name (If not institution, give	*			4b. City,	Town, or	Location o			4c. Cou	unty of Death	
			Genesis Heritage				ctr.			unda	lk			Baltimore
	Funeral		5. Social Security Number 6. Se	]M 2⊠F	e (In yrs. las	st birthday) Yrs.	Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	year 2006 1:00  Year 2006 1:00  Dounty of Death Balt:  28 9. Birthplace (State or Country)  Maryland  10d. Inside City 1	ntry)
	Director		219-22-5982 Usuel Residence of Decedent		77	115.					Nov.	, 192	8 Mar	yland
	yland Now		10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits
	Man	to	Maryland Bal	timore							Dunda	1k		1 ☐ Yes 2 ☐ No
	th the	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	ntry?
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	tement and the second	ne	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.		Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			
36	s afte	Ž.	1 Never Married XX Married	1 ☐ Yes 2X N If Yes, Give	lo		1 ☐ Yes 2		Specify:		, ,	i	ncify:	
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5	in 72 na na	ojet	(Specify only highest grad	e completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	lurina most	of worki	ng	16b. Kind o	f Business/In	dustry
25	y with	E	Elementary/Secondary (0-12)  12 Years	College (1-4or 5	+)		phone			er		Comm	unicat	ions
פ	e filec othe vent,	BeC	17. Father's Name (First, Middle, Last)								(First, Middle,		-	
<u>Ja</u>	Venta Venta	10E	Henry A. Vogt								Marga	aret P	unte	
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Ty											
	and and marking an		Mr. Lyle Lee More	land (Hus			Aldw		Road	l Du	ındalk,	Maryl	and 2	1222
ore	of H of H or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F	lemoval from State	20b. Plan	ce of Dispo netery, crei	sition (Nan natory or ol	ne of ther place	9)		ate	20c. Location	on - City or To	wn, State
Ē	Pag ment tant: lury o		4 ☐ Donation 5 ☐ Other (Specify)	omova nom otalo	Hil	ltop	Servi	ce C	orp.	9/12	2/2006	Tows	on, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Juneral Service Licens	Meion	_	D	uda -R 922 W	uck	Funer	al F	ome of	Dunda	lk, In	
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587	icate phys s the	dical												
Box (	that the death certific ed by the ettending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	of pregnanc	;y						234	Date of deline	
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o.	t the carbon arches	hys	9 Unknown	9□ Unknown				,,						
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<u>s</u>	tend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 □ N	lo				
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home (Specify)	e, farm, str	et, factory,	office		2	8f. Location (S City or Town	treet and Nu n, State)	mber or Rura	Route Number,
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	6		30. Name and address of person who co									1 1		
	$\boldsymbol{\nu}$		Harjit Singh, M.					у В	altim	ore,	Maryla	nd 21	1225	
	Sta		31. Date filed (Month, Day, Year)	3 Registrar	's Signatur	la de	10							
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7	Examir	er	Howard	_		1 11.	46. City, 1	own, or	Location o	r Death		140	nty of Death	0
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1		If Under 2		8. Date of Birth (Month, Day	, ,		place (State or Foreign
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	3a or	Funeral Director	2963 Normand	v Drive				2104	43			rog. Citizeri t	USA	my r
	death ms 2; rms 2;	era	11. Marital Status	12. Was	Decedent Ever in	n U.S. 13.				gin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ	
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Ba	Depertrement Importations on Injurial Processing September 1		21. Signature of Funeral Service	1/7/1		25	remat 199 Fr	ion eder	Socie ick	ety Road	Of Mary Baltim	land, ore, M	Inc. lary <b>1</b> ar	nd 21228
8760,	Physician /Medical Examiner   pennal-itansi	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Pae to (or as a consule to (or a) to (or as a consule to (or a) to	sequence of):								Interval Between Onset and Death
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Vital	ician: Th certificete rector, pag	0	25. Was case referred to medic	al Cies	9	Hypothy	010		26. Place	of Death	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	2 <u>1</u> N0
of V	Physician: this certificantal director, i	To B	examiner?	Hospital:	1 Distrient 2	R ☐ ER/Outpatien	t 3 DOA	Othe	~		ne 5 ☐ Resid		ther (Specify	()
	ding Pi	ö	27. Manner of Death 1 ☑ Matural 5 ☐ Pend	28a. [	Date of Injury (Month, Day Year,	28b. Time of Injury		c. Injury Work	at ?	2	28d. Describe h	ow injury occ	urred	
Sio	Attending r death. ector: After by the fune	cat		tigation			М		es 2□N		201 1 11 10			
Division	l or Attendater deatl Director: In by the	Certification;		mined 286.	Place of Injury - A building, etc. (Spe	at nome, farm, str ecify)	eet, factory, o	office		1,	City or Town	reet and Nur n, State)	nber or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours alter death.  To the Funerel Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certify	ing Physician: T	o the best of my i	knowledge, death	occurred at	the time	e, date and	place, a	and due to the c	ause(s) and i	manner as st	ated
	n 24 l n 24 l he Fu	edlcal	(Check only 2 Medice one)	el Examinar: On t	the basis of exam manner stated.	ination and/or inv	estigation, in	п ту ор	inion, deatl	h occurre	ed at the time, d	ate and place	e, and due to	the cause(s)
	To t To ti	Ž	29b. Signature and title of certif	er /	1	1			number			_	ned (Month, I	
7	140		17	41	<u></u>	- 11	2	1	Y	161	20	Sept	9	2006
	17		30. Name an oddres of perso	n who completed	cause of death (I	tem 23a) (Type,	Print)	11	,		2	60		2006 72 21043
	Sta	te.	31. Date filed (Month, Day, Yea	r) :	32. Registrar's Sig	gnature	/	OTO	cent		rusy	1010	יסומייי	72 21043
	Registr		SEP 1	2 2006	Jan Carles	AR A	and a	t						

State of Maryland / Department of Health and Mental Hygiene 2006 28827 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) r 9, 2006 **Physician** September 4:27am M JoAnn Louise Morfoot /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ MD 82 219-18-0059 Nov. 18 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Exercises must be notified at 1 ☐ Yes 2 ☐ No Director White Hall **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 USA 21161 by Funeral 2805 Anderson Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Social Security Post Office Manager 12 n/a other traumatic avant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Kuhnle Clinton Clinedinist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2805 Anderson Rd., White Hall, MD 21161 Susanne Reinhart/daughter more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/12/06 ₹ 1 Burial 2 Cremation 3 Removal from State = 6 permit. Page Department of Important: if any injury or once. Timonium, MD 4 Donation 5 Dother (Specify) Entombment Dulaney Valley Mausoleum 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, M.D. 21093 Michael Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the dailying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 mooths? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 ₽No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (Inpatient 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA Alter this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No efter death.

I Director: Al investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 | Homicide within 24 hours ele To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Cyntina Sviano la D51347 m 23a) (Type, Print). Charles ST Baltmore MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YNTHIG SOCIANO MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 2006 28828 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year 030 McMullen Wra Otember 2000 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Aug. 15, 1944 Medical Cents Maniford U 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 10 M 20 F 212-46-3702 62 Maryland Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

other than "natural", or itams 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or Itama 23a or 28a-i ahow the Medical Examinar must be notified at 1 X Yes 2 ☐ No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3711 MacTavish Ave. 21229 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 24No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White φ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Appliances 8 Factory Worker Mother's Name (First, Middle, Maiden Sumame)
Madeline Smith 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: If Itam 27 is marked oth any linjury or other traumatic avant SDRS. Be Richard C. Lizer 19a. Informant's Name/Refationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernetta Fleishell, daughter 321 Johnson Farm Lane Glen Burnie, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriaf 2 □ Cremation 3 □ Removaf from State Meadowridge Memorial Park 09-13-06 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respirator arlure 3 hrs. /Medical Due to (or as a consequence of) Examiner - Bronchial hemorrhage Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificete 212 No 2 🗆 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Funeral Director; After the completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 1 Natural 2 Accident 28a. Date of fnjury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation м 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 22 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar		State of M	arylan	id / Depa <i>Cer</i>	ırtmei <i>tifica</i>	nt of H te of L	ealth and Death	Men	al Hygi Rei	ene (	2006	288	829
1000	Physici		1. Decedent's Name (First, William B. M		Sr.						- N	Pate of Death Month	Day OG	Year 2006	3. Time of D	Δ.,
	/Medic Examin Funeral		4a. Facility Name (If not ins 3T AGNE 5. Social Security Number 214-05-3236	s H	street and number)	L	last birthday) Yrs.		r 1 Year	Location of Dec	ath E	eate of Birth	4c. Co	ounty of Deat		
	Director		Usual Residence of Deceder	ent			ty, Town or Lo	cation				<u> </u>		riar y	10d. Inside City	Limits
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	23a or	Funeral Director	420 W Maple					210	)90		(0 11 )	U.	S.A.	•		
920	ours after de rai', or item Expuilier d	<u>م</u>	11. Marital Status  1 Never Married 2  3 Widowed 4 Div	Marned	12. Was Decedent Amed Forces? 1 (2) Yes 2/1 If Yes, Give 1/ Year or Dates:	Ever in U 12/4	5 13. v	Vas Dece Yes, spi		ispanic Origin? In, Mexican, Pue Specify:	(Specify ) erto Ricar	Yes or No- n, etc.)		. Race · Ame Black, White pecify: Whi	, etc.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important if item 27 is marked other than "natural, or iteme 23a or 28a-f show any injury or other treumatic event, the Modical Examinations and injury or other treumatic event, the Modical Examinations and once.	Completed	15. De (Specify only Elementary/Secondary (C		cation e completed) College (1-4or	5+)	16a. Deced (Give life. L Purcha	kind of w OO NOT	ork done d ise retired	furing most of w )	vorking	N		of Business/l inghous tric		
and ?	i be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, M		nh.					18. Mother's N				ımame)		
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imore,	Pages 1 ament of Heanant if Item		20a. Method of Disposition  1 Burial 2 Crem  1 Donation 5 Ot		emoval from State	20b. F New	Λ	frai	Ceme	tery 9-		06 Ba	ltin		ryland	
Balt	Departi Departi Import any inj		21. Signature of Funeral So	ON	Tokal	leaf	100/1	328	Sulph	ss of FacilityAm ur Spri	ng R	d. Art	utus		227	
	Physician /Medical Examiner		23a. Part 1. En er ti e disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ise, or compli	cause on each ii	no. FDI	OMYC				ac or res	piratory arres	it,		Approximate Interval Betwee Onset and De	
68760,	ificate be executed physician and as the burial-transit	edical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as											
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rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant co	onditions cor	ntributing to death b	out not res	sulting in the ur	nderlying	cause give	en in Part I.					the cause of dea	
Division of Vital Records,		Completed	[]						· · · · · ·	· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy performe	ed?	prior to death?	opsy findings av ompletion of cau 2 2 No	ailable use of
\	ysician: The l is certificete ha director, page	o Be	25. Was case referred to mexaminer? 1 Yes 2 No	- 77	lospital:	ent 2	ER/Outpatien	t 3 🗆 D	OA Cthe	26. Place of D				Other (Spec	ifu)	-
ion of	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifior completely filled in by the funeral director,	ation; T	27. Manner of Death 1 Natural 5 1 2 Accident	Pending nvestigation	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		28c. Injun			Describe how				
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)	T witi		29b. Signature and title of c	Plantine	-5	dan		25	C License	2900		1	32 p	igned (Month	,200	6-
	5+1		30. Name and address of p	en f	turnue	B	AUTIS	nor	<del></del>	up 2	122	9 E	tie	nne 1	Vgouma	ina.
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NURPHY, William

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Physician Medical Examiners  The state of the disease, or completation final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indeed the state of content fallow. It is might be caused to make the state of content fallow. The state of con	Balt	permit. Departimport. any inj		1 pri	'XEL	ang	- <u>X</u>	IRKLEY 21 CRA	-RUD IN H	DICK FUN WY. S.E.	ERAL HO GLEN	ME, P BURNI	A. IE, MI	21061
The following of the second property of the s				Immediate Cause (F disease or condition	inal		d the death. Do not en ine.	ter the mode	of dying, s	such as cardiac or	r respiratory arr	est,		Interval Between Onset and Death
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25. Was case referred to medical sexaminer?  1	Recol	ne law rec e has bee ge 2 shou	mplete								autop: perfor	sy med?	prior to death?	completion of cause of
1   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, tarm, street, factory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   JIANYI ZHANG, M.D. VA MAryland Health Care System   Perry Point, MD 21902	ta			25. Was case referre	ed to medical				2	6. Place of Death			I L Yes	2 NO
1   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, tarm, street, factory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   JIANYI ZHANG, M.D. VA MAryland Health Care System   Perry Point, MD 21902	Ž	yalci is cer direct			No	Hospital:	ient 2 ☐ ER/Outpatie	nt 3 DOA	Other				Other (Spec	cify)
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Jiany: Zhang M. D. 01010580281  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D. VA MAryland Health Care System Perry Point, MD 21902	Sio	eath. or: Ay	catle	2 Accident	investigatio									
Jiany: Zhang M. D. 01010580281  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D. VA MAryland Health Care System Perry Point, MD 21902	Divi	af or Ats after d	Sertifi			280. Place of It	ijury - At home, farm, st rtc. <i>(Specify)</i>	reet, factory,	office	2			mber or Hu	irai Route Number,
Jiany: Zhang / W. D. O1010580281  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D. VA MAryland Health Care System Perry Point, MD 21902		Ne Hospit	edical	(Check only 2	1 Certifying Pl 2 Medical Exa	miner: On the basis	of examination and/or in	th occurred at nvestigation, is	the time, n my opin	date and place, a ion, death occurre	and due to the coed at the time, co	ause(s) and late and plac	manner as	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D. VA MAryland Health Care System Perry Point, MD 21902		To the within To the comp	Z		7	<b>.</b>					2	29d. Date sig	ned (Monti	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D. VA MAryland Health Care System Perry Point, MD 21902		_		• ]	Tanyi	Zhang.	M. D.	01	.0105	80281		Sector	ber :	3, 2006
State Registrar SEP 1 2 2006 32. Registrar's Signature		7				D. VA MA	ryland Heal	lth Car	re Sy	stem Pe	erry Poi	energy and		04 -057.5
						32. Regist	trar's Signature	,						

			1 - For State Registrar	State of Ma	ryland / I	Depar <i>Certi</i>	tment of H ificate of I	ealth and I Death	Mental Hy	giene Reg. No	200	6	28831
Ner-	Physici /Medic		1. Decedent's Name (First, Middle, Las Elsa Mitchem	it)					2. Date of De Month Septemb	ath Dag	y 10 20		Time of Death 12:30P M
	Examin Funeral Director		4a. Facility Name (If not institution, give 250 S. President 5. Social Security Number 6. S 212-30-6107	Street Co	ndo 601 (In yrs. last bi 79	1 nthday)		Location of Death OTE CITY If Under 24 Hrs. Hours Min.	8. Date of Bir	th y, Year)	. County of De	N/A Sirthplace Country)	(State or Foreign
	<b>D</b>	or	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City, Tow Baltir				<u>pe tobel</u>	10,	,1520 P	10d. lr	nside City Limits
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or itame 23a or 28a-f show event, The Madical Extrainer must be mailied at	Funeral Director	10e. Street and Number 250 S. President		ndo 601		10f. Zip Code 21202				izen of What ced Sta	Country?	
0030	72 hours after dea natural', or Itame	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.		is Decedent of Hi es, specify Cuba	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, WI Specify: W	nite, etc.	
0-6121	within 72 ho ene. than "natur ne Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+ N/A	`	(Give kii life. DC	nt's Usual Occupa nd of work done of NOT use retired Maker	ation furing most of wor )	king		ind of Busines		у
Jana z	ould be filed I Mental Hygir Mrked other natic event, II	To Be Co	17. Father's Name (First, Middle, Last) Ernst Schneider					18. Mother's Nan					
e, mar	1 and 2 sh Heelth and em 27 is m ther traum		19a. Informant's Name/Relationship (1) Mr. Christopher J 20a. Method of Disposition		(Son) 4	160 P	eacock I	1		svil		rgin	ia, 22903
baitimor	permit. Pages Depertment of Important: If It eny injury or o		11 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	v)	Dulane	ory, crema Ey Va 22, 1	tory or other place 11ey Men	s of Facility	.15,2006	Timo	onium,	Mary.	land
,	Physician and /Medical past the burial-transit as the burial-transit	edical Examiner	23a. Part 1. Errier the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	consequence	of):	the mode of dying	Road Time g, such as cardiac	or respiratory a	rrest,		App	ctr. P.A.
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②☑ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death		ctopic pregnancy other (specify)				23d. Date of d Month	lelivery Day	Year
cords, r.	equires that the sensigned by tould be deta	þ	Part II. Other significant conditions o	ontributing to death but	t not resulting i	in the und	erlying cause give	en in Part I.			use contribute		use of death? 4⊠Unknown
ital nec	in: The law i ificate has b or, pege 2 st	e Completed	25. Was case referred to medical					00.0110	1 ☐ Yes	rmed? 2X No	prior to death	complet	indings available ion of cause of No
DIVISION OF VI	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours elect death cert within 24 hours elect death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification; To B	examiner?	28a. Date of Injury (Month, Day	y - At home, fa	Time of Injury	28c. Injury Work M 1 🗆 Y	4 C Hursing H	ome 5 Residence 128d. Describe to 28f. Location (Scity or Town	dence now injur	ry occurred		ıte Number,
3	Hospital 24 hours e Funeral E etely filled	edical Ce	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	examination ar	e, death o	ccurred at the tim stigation, in my op	e, date and place sinion, death occu	, and due to the tred at the time,	cause(s) date and	and manner and di	as stated. ue to the o	cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier		m	D.	29c. License	number P3F0		29d. Dat	te signed (Mod	onth, Day,	Year)
1			30. Name and address of person who	Mere	cy/	Type, Pr	oth C	301	ST. PA	il		21	201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 2	32. Redistra	s Signature	do	Selen of		*				

			For Amend #26 Perstate Registrar  1. Decedent's Name (First, Middle, Last)			Cei	tificat	e or L	Jealii		2. Date of Deat		UU6	2883 3. Time of Death
	ysicia /ledica	ก	Ina Louise Mi								Month	<sup>D</sup> <b>0</b> 3	2006	
	amine	er	4a. Fecility Name (If not institution, give : Bayview Hospital	street and numbe	or)		4b. City,		Location o	ol Death			nty ol Death	
Eun	oral		5. Social Security Number 6. Sex	7. /	Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birth		9. Birthp	lace (State or Foreig
Fun Direc				M 2⊠F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 02/05/	1925	MS Coun	try)
pur *		- H	Usual Residence of Decedent  10a, State 10b, County		10c Cit	y, Town or Lo	cation						11	0d. Inside City Limits
Maryla	a Da	. 1	MD Baltimore	9		dalk								1 Yes 2 □ N
r 28a	Hour I	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Coun	try?
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Maryland with the Maryland within 72 hours after death with the Maryland piene.	xaminarm	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Tes 2 If Yes, Give Year or Dates	s? No		Vas Deced I Yes, sped I □ Yes	cify Cuba	spanic Ori n, Mexican Specity:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	В	lace - Americ lack, White, e c <sup>ify</sup> White	etc.
2 hou	E lea	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usua	al Occupa	ition			16b. Kind of	Business/Inc	
d within 7 giene. er then "n	the Med	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-40	r 5+)	Print	00 NOT u	nk done d se retired	lu <i>ring</i> mosi )	or workir	I I	Printi	.ng	
ind year to 2 12 12 2000	- N	To Be (	17. Father's Name (First, Middle, Last) Unk Hales						18. Mothe	ur's Name Unkn	(First, Middle, A	Maiden Sum	ате)	
	other traumatic		19a. Informant's Name/Relationship (Ty Mr. Charles Mitchel			1911	Ware	ham I			Alk, MD	-		Code)
00-	<b>-</b>		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat		Place of Dispo cemetery, crem esapeak	natory or o	ther place		S	<b>ep</b> 7		ille, M	wn, State aryland
permit. Pag Department Important: I	eny Inj		21. Signature of Funeral Service Licenson	in Mo	144	3 8	717 G1	ceen	Pastu	res D		ltimor	e, Mary	land 21286
Physic /Med Exami	ical iner	iner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	iline.	e ( eu	1		nath .		etwi			Approximate Interval Between Onset and Death
	the but	/Medicai Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Feta	ancy	Ectopic pr						Date of delive	ry Day Year
that the d ed by the	detached	Physi	1 ☐ Yes 2 MNo 9 ☐ Unknown Part II. Other significant conditions cor	9□Unknown					o in Part I		23e Did tob	2000 UEB 00	natabuta to th	e cause of death?
The law requires that the	8 .	۵	Nypertus c	ú-								s 2 No		
	page 2	Completed	aghernmer	s UI	sla	*					24a. Was ar autopsy perform 1 Yes 2	/ _	prior to con death?	osy findings available apletion of cause of 2 No
Physician: this certific	S 1	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	tiont 2	ER/Outpatien	t 3 🗆 DC	Othe			(Check only one ne <del>5 Difesi</del> de		Nhas (Caralle	1
Affe in			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In		28b. Time of Injury		8c. Injury Work	at	2	8d. Describe ho		Other (Specify curred	)
고 # 전	filled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i>	ome, larm, stri y)	eet, factory	, office		2	8I. Location (Str City or Town	reet and Nur , State)	mber or Rural	Route Number,
5 4 T	ely fill	edicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best ner: On the basis and manner:	of examina	wledge, death tion and/or inv	restigation	, in my op	inion, deal	d place, a th occurre	nd due to the ca	use(s) and ite and place	manner as sta e, and due to	ated. the cause(s)
To the Within 2 To the	COU	Σ	29b. Signature and title of certifier	2 4-1		,		. License		01			ned (Month, L	
D			30. Name and address of person who co		f death (Iten	n 23a) (Type,	Print)	D~	780	71	ghea 1	7/6	106	7 125
			KUMO LO HICA	NASI	UM	1) 49	1164	$ \chi$ $\mid \nu$	1 . / 0	011	11100 /	VALL S	C 1 / 10	V 1-11

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year MARTIN SARAH SEPTEMBER 11:45 AM 8 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 14, 1933 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗶 F So. Carolina 247-54-9497 73 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23s or 28s-f ehow Examiner must be notified at X 1 ☐ Yes 2 ☐ No **Baltimore** N/A Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21225 928 Bridgeview Road Funeral Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed other than "natur vent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earline Milo and Mental James C. Milo 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 Brdigeview Road Baltimore, Maryland 21225 item 27 i William Martin, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 09/12/06 Laurel, Maryland Maryland National Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Significant of Funeral Service Licens 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HIYPOXIA HOURG /Medical Due to (or as a consequence of): Examiner PHEUMONIA Schenitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exam resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical the th nding p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) the i 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, VENOUS THROMBOSIS 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown RHABDOMYOLYSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 2 No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Annatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🕱 No this ierei Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel (
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the } 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , M.D. RES 000 SEPTEMBER 8 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHANA PAUNITER n 3001 SOUTH HANOVER STREET, BALTIMORE HARBOR HOSPITAL MD 21220 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-06663 Cindy L. Mervis

# Please Type or Print in Black Indelible Ink of Maryland / Department of Health and Mental Hy

Silidy C. Mervis		I-For State Registrar	tate of Maryland		rtment c		na ivientai —		Reg	No.	200	6 21	883
Physician Medical Examine	4	Decedent's Name (First, Mid- CINDY	dle,Last)			M	EDVIC	Mo	te of Death nth [ ptember	Day	Year	3. Time of Dea 2013 hrs	
pg Edmin		4a. Facility Name (if not instituti	ion, give street and number	r)		4b. City, Town, o	ERVIS or Location of D		ptember		unty of Death		
		5 Harness Court Apt	104			Pikesville				Balt	imore Cou	nty	
Funeral Director		5. Social Security Number 528-92-0381	6. Sex 7. A	ge (In yrs. Ia 47	ist birthday) Yr	If Under 1 Ye Months Da			ate of Birth		Foreig	hplace (State of n <b>Utah</b> untry) <del>UTAL</del>	
any	- 1-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Loca	ation						10d. Inside Cit	y Limits
*	۱	MD BAL	TIMORE		BALTI	MORE						1 Yes 2	X No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen	of What Coun	try?	
ith the		5 HARNESS CO	URT APT. 104		e I 40 M	2120		1/ 6	(	144	U.S.A.	L. Fra Dir	
eath w	runerai		Married Armed Forces	?		as Decedent of H Yes, specify Cuba					White, etc.	can Indian, Blac	CK,
after d	<u>-</u>	- A	ivorced If Yes, Give Year or Dates:	No No	1	Yes 2 N	o specify:			Spe	cify: WH	ITE	
hours		15. Decedent's Education (Sp Elementary/Secondary (0-12			16a. Decede during r	nt's Usual Occupa nost of working lif	ation (Give kind e. DO NOT use	d of work do retired)	one 1	6b. Kind	of Business/Ir	ndustry	
thin 72 than 72 than	Completed	Ziementary/oddonaary (0-12	4		CLIN	ICAL DIE	TICIAN			M	IEDI CAL		
ID 21215-0036 should be filed within 72 and Mental Hygiene and Mental Hygiene in smarked other than 'n in marked other than 'n To Do Complex		17. Father's Name (First, Middle	e, Last)				18.Mother's N		Middle, Ma	iden Surr	•		
2121 ald be f Mental marked event.	9     0	BOB  19a. Informant's Name/Relation	ship (Type, Print.)	C	ARTWRI	GHT ng Address (Stre	DER		oute Numbe	er City o	UN State	OBTAINA Zin Code)	BLE
and 2 shou and 2 shou tealth and N ten 27 is n traumatic	-	ABRAHAM MERV			4908	SOUTH 4	050 WES	ST ROY	Utal	t± 84	067	210 0000)	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene ent of Health and Mental Hygiene in: If item 27 is marked other than "natural", or items 23a or 28a-fish in the irraumatic event, the Medical Examiner must be notified at once To Do Completed by Elinoral Disorber	- 1	20a. Method of Disposition  1 Burial 2 V Crematic	on 3 Removal from S			sition (Name of co		Date			ition - City or	Γown, State	
Baltimore, permit. Pages 1 ar Department of He Important: If ite Important: If ite Imjury or other tr		4 Donation 5 Other 8	Specify:	HILI		ERVICE C		9/11/	2006	TOW	SON, M	D	
Baltin permit. J Departm Importa	- 1	21. Signatur of Funeral Silvic	4			Name and Addres	Ť	SOL	LEVIN	SON	& BROS	., INC.	
Physician	1	23a. Part I Enter the disease, of failure. List only one caus	or complications that cause	d the death.	Do not enter	the mode of dying	such as cardi	MN R( ac or respir	atory arrest	DIKE t, shock, i	SVILLE or heart	Approximate	In erval
/Medical Examiner		Immedia e Cause (Final diseas	<sub>e a</sub> Bronchopn									Between Ons Death	
	-	or condition resulting in death)	Due to (or as a cons	sequence of	):								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of	):								
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60, ate be e shysician	Medical	X UNPENDED  IF FEMALE:	X AMENDED  23c. If yes, outco	em#8.9	19b pe	rFH 23a 2	7.perME	G859	9/21/0		ite of delivery		
687 ertifica ding pl		23b Was decedent pregnant in past 12 months?	the 1 Live birth		2 F	etal death 3	Ectopic pre	egnancy		Mor		ay Ye	ear
Box 687  e death certific  the attending p  ed for use as the	Physician	1 Yes 2 No 9 🗸 U		at time of dea	<sup>atn</sup> 5 C	ther (Specify)				ĺ			10
o. D. En nat the decarbed by the etached	y y	Part II. Other significant cond	itions contributing to dea	th but not re	sulting in the	underlying cause	given in Part I.	2	3e. Did toba			he cause of dea	
S, P puires ti an signe	Da.							_				ably 4 🗸 Unk	
Division of Vital Records, P.O. Bilal or Attending Physician: The law requires that the start death.  The law requires that the all prectors. After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed					<del></del>		_	4a. Was an autopsy perform			opsy findings a empletion of cau	
tal Rections: The certificate ector, page		25. Was case referred to medic	at I			26 Place	e of Death (Ch		✓ Yes 2	No	1 Yes	2	No
Vital Pysician:	ן מֿ	examiner?  1 Yes 2 No	Hospital:	ient 2	ER/Outpatier		Other:	ursing Hom		sidence	6 Other:	Scene	
n of Jing Ph	<u>-</u>	27. Manner of Death	28a. Date of Inj (Month, Day,		28b. Time of	· · ·   ·	ury at Work?		escribe hov	w injury o	ccurred		
Sion Attend death. ector:	Catic	Fer Ser	estigation				Yes 2 No						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfered Contribution Contribution I. De Completed by Directory Madical Experience of the contribution o	Certification:		uld not be ermined (Specify)	njury - At no	me, tarm, stre	eet, factory, office	bullaing, etc.		Town, Stat		lumber or Run	al Route Numbe	er, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying I	Physician: To the best of r										
To the Hos within 24 h within 24 h completely	ᄝᄂ		aminer: On the basis of exa and manner stated	amination an	nd/or investiga			ed at the tir					
	2	29b. Signature and title of certif	HALL	de		29c. Licen	.M.E.				signed (Mon nber 6, 200	_	
7		30. Name and address of perso Carol Allan, MD As	n who completed cause of ssistant Medical Exa			Street, Baltim	nore, MD 21	1201					
Stat		31. Date filed (Month, Day, Year	Registr	ar's Signatur		v.							
Registra	ar	SEP 1 2	2006 General	1 15	1					_			

DHMH 17 Rev 1/2001 OCME 2006

06-06582 Donald E. McGhee

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Criticate of Death Reg No. 2006 28	8.7
Physician/ ledical Examiner		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2517 Washington Boulevard 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-90-9098 6. Sex 7. Age (In yrs. last birthday) 36 Yrs. Months Days Hours Min. 5/11/1970 Foreign Country) DC	
te Maryland or 28a-f show any fied at once. Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Baltimore  1 x Yes 2	
n with the Maryland ms 23a or 28a-f sho be notified at once eral Director		
fter death ", or ite er must	3 Widowed 4 Divorced in test give rear or Dates:  1 Yes 2 No specify: Specify: WIII Le	
5-0036 led within 72 hours after Hygiene. to ther than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Roofer Housing	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE Comple	Donald McGhee Sr. Blanche Mitchell	
MD nd 2 shc alth and sm 27 is	Blanche Mitchell/mother 2517 Washington Blvd Baltimore MD 21230  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State	
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other ti	1 Burial 2 X Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Chesapeake Crematory 9/12/06 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA 21233	
Physician /Medical	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  8717 Green Pastures Dr. Baltimore, MI Approximate International Approximate International Approximate International Control of the In	erval
Examiner	Immediate Cause (Final disease or condition resulting in death)  A NArcotic intoxication  Due to (or as a consequence of):	
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
execu an and al - tra		
<b>8</b> ta at <b>9</b> €	23h Was decedent pregnant in the	
P.O. Boy s that the deat gned by the att e detached for by Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death	
aw requires as been sign 2 should be	Cocaine use  1  Yes 2 No 3 Probably 4 Unknor  24a. Was an autopsy performed? 24b. Were autopsy findings avail prior to completion of cause death?	lable
Vital Recysician: The Institute In Institute In Institute Institut	(Check only one)	0
1 of Vit ting Physic After this c funeral dire	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Vother: Scene	
ion of tending P eath.  tor: After the funera	5   1   Natural 5   Pending   Fnd 9/3/2006   Fnd 5:40 am   1   Yes 2   No   unk	
Division ospital or Attenchours after death hours after death uneral Director: y filled in by the Certification	Natural 5 Pending Investigation 2 Accident 3 Suicide 6 X Could not be determined 4 Homicide 900 Settlines 900 Sett	City
To the Host within 24 hc To the Fun completely:	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 3, 2006	
	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	man garden de la companya de la comp	

			epartment of Health and I Certificate of Death	Mental Hygie	ne.2006 28837
Physic	ion	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
/Medi	cal	MINNIE MOORE	Al- Ch. Toward and Booking of Booking	August 18	
Exami	ner	4a. Facility Name (If not institution, give street and number) Bethesda Health & Rehab. Center	4b. City, Town, or Location of Death Bethesda, Mary1		4c. County of Death  Montgomery
Funeral	47 (10)	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
Director		578-20-7005 1□M 2\(\text{\text{\$M}}\) F 90 Yi	s. World's Bay's Trout's William	Jan. 8,	1916 Raleigh, NC
land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town			10d. Inside City Limits
Many	to	MD Montgomery Rockvil	le		1X Yes 2 □ No
or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
e 23a	gra	6111 Montrose Road, #104	20852		US 14. Race - American Indian,
fter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	o Rican, etc.)	Black, White, etc.
172 hours after death with the Marylar 172 hours after death with the Marylar 178 hours of teme 23e or 28e-1 ehow 178 office! Exertified at	þ	3 ¼ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Black
be filed within 72 hours after death with the Maryland tall hygiene. Indicate than "natural", or Itame 23a or 28a-1 ehow event, the Modical Examinational by recitional	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired)	king 16	b. Kind of Business/Industry
withir iene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker	ç	Self Employed
other vent,	Φ	17. Falher's Name (First, Middle, Last)	75	ne (First, Middle, Ma.	
C should be filed within and Mental Hygiene.	To B	Willie Pulley	Hattie	Dunston	
12 sho			Mailing Address (Street and Number or Ru		
T and 1 and Health		20a Method of Disposition 20b, Place of D	22 Woodreed Dr., Br.	Date 20	Maryland 20613 c. Location - City or Town, State
Pages ent of nt: If It		1 Purial 2 A Cromation 2 Pamoual from State Cemetery,	ale Park Crematory	26/06 R	liverdale, MD
permit. Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 Ie marked eny jollury or other treumatic enge.		21. Signature of Funeral Service Ligenbee	22. Name and Address of Facility Fra		
0 82E88		Christian State	389 Rhode Island Av	zenue, N.W	., Wash., DC 20001
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a CONCESTUE  Due to (or as a consequence of		ATHY	
Examiner		LYDERT			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
and I-trans	Examiner	Cause (Disease or injury that initiated events c	).		
icate be executed physician and sthe burial-transit	alE	500 10 (01 43 4 801354461.00 01	,,		
ufficate g phy: as the	edical	d			
Joan Death certific attending p	Physician/Me	## 1	3 Ectopic pregnancy		23d. Dale of delivery  Month Day Year
the at	ysici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  9 □ Unknown	5 ☐ Other (specify)		Month Day Year
that the ed by detac		Part If. Other significant conditions contributing to death but not resulting in I	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
quires nn sign uld be	ed by			1 ☐ Yes	2 No 3 Probably 4 Unknown
aw re	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The sate he page	Completed			performe	d? death? 7No 1 ☐ Yes 2 ☐ No
v Ita	Be	25. Was case referred to medical examiner?		th (Check only one)	
Phys arthis sraldi	J: To	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	ome 5 Residence 28d. Describe how	e 6 □Other (Specify) injury occurred
ath.	atlo	1 Natural 5 Pending (Month, Day Year) Inj 2 ☑ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
pitel o		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death convered at the time, date and place	and due to the cause	ca(c) and manner as stated
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  Addical Examiner: On the basis of examination and/and manner stated.			
To the within To the comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
Ĭ.		Acparingo	D-27 -		8/31/06
K		30. Name and address of person who completed cause of death (Item 23a) (TALPANA GOSWAMI, M.D 1119 Rockvil	· ·	MD 20852	(Suite 100)
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TE TIRE, NUCKVITTE,	TID 20032	(Dutre 100)
Regist		SEP 1 2 2006	Coselli B		

		•	1 - For Amend #18 Pe	er FH 6859	aryland/ 	Depa Cei	rtment o tificate d	f Health a of Death	and M	ental Hy	giene <sub>Reg. No.</sub> 2	2006	28838
	Physici /Medio		Decedent's Name (First, Middle, Last     Donald	Maxwell	L	Morg	gan			2. Date of De Month 09/11/2	Day	Year	3. Time of Death 7:40 A M
	Examir Funeral		4a. Facility Name (If not institution, give 623 Douglas Stree 5. Social Security Number 213-22-4055	t	a (in yrs. last b	irthday) Yrs.	4b. City, Tow Brook If Under 1 Ye Months Da	ar If Under		8. Date of Bin (Month, Da	An th y, Year)	ne Arun  9. Birthp  Coun	lace (State or Foreign
	Director		213-22-4055  Usual Residence of Decedent  10a. State  10b. County		79 10c. City, To		cation	]		08/21/	1927	11	MD Od. Inside City Limits
	h the Mar or 28a-f et e notified	Director	MD Anne Arr	unde1	Broo	k1yr	10f. Zip Coo	8			10g. Citizer	n of What Coun	1 ☐ Yes 2 🖾 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral D	623 Douglas Stree  11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent I Armed Forces?		13. \	2122 Vas Decedent f Yes, specify (		igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	U.S.	A .  Race - Americ Black, White,	
Maryland 21215-0036	72 hours af natural', or lical Exam	ted by F	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	1 ⊠ Yes 2 □ N If Yes, Give Year or Dates:		a. Deced	l ☐ Yes 2 ☒ lent's Usual Ookind of work do	cupation		20		of Business/Inc	hite
12121	iled within ' Hyglene. ther than "r nt, the Med	Completed by	Elementary/Secondary (0-12) 10  17. Father's Name (First, Middle, Last)	College (1-4or 5		life. I	tricia	tired)		(First, Middle,		trician	
ıryland	should be f nd Mental h marked of matic eve	To Be	Chester Morgan  19a. Informant's Name/Relationship (7)	vpe. Print)	19	b. Mailir	a Address (Str		Anne	o Oster	Lin	a C. Os	
re, Ma	is 1 and 2 is of Health ar item 27 is other trau	I	Mrs. Bernice L. Mo 20a. Method of Disposition	organ /wii	e 20b. Place	623 of Dispo	Dougla sition (Name of natory or other	s Stre	et;		n, MD		
Baltimore,	permit. Page Department of Important: If any injury or once.	1	1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Service Licers	)	1	peak	e Crema	tion				ensvill ral Hom	
8	80 E # 9		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	lications that caused ne cause on each in	the death. Do	not ent	er the mode of	tying, such as	cardiac o			MD 2106	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence		du C	lnes		·			Onset and Death
o,	g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence								***************************************
P.O. Box 68760,	The law requires that the death certificate bete has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal deat		Ectopic pregna				23d	I. Date of delive Month	ry Day Year
ords, P	w requires that been signed t should be deta	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the ur	nderlying cause	given in Part I	l.		obacco use res 2□N		e cause of death? ably 4 Unknown
Division of Vital Records,	i: The law ricete has be	Completed										prior to con death?	osy findings available inpletion of cause of
Ĕ	siciar certif irecto	o Be	25. Was case referred to medical examiner?	Hospital:	nt 2□ER/O			Other		(Check only o			
ion of	nding Phy ath. r: After this ie funeral d	atlon: To	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. l	njury at Vork?	2	28d. Describe h		Other (Specify courred	7
Divis	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc.		farm, str	et, factory, offi	ce	2	28f. Location (S City or Tox	Street and N vn. State)	lumber or Rurai	l Route Number,
	To the Hospital within 24 hours a to the Funeral completely filled	Medical	29a. Certifier (Check only one)  29b. Signature-and title of certifier	rsician: To the best of inar: On the basis of and manner sta	examination a	ge, death nd/or inv	restigation, in m	a time, date an y opinion, dea ense number	nd place, a ath occurre	ed at the time,	date and pla	d manner as sta ace, and due to igned (Month, L	the cause(s)
)	/		30. Name address of person who or	)	ath (Item 23a)	(Type		123	155	-/	Sex	Horbe	- 11,2006
	5 Sta	te	31. Date filed (Month, Day, Year)	Dans.	sath (item 23a)	7	250.0	Lal D	1680	60	Sun	-64	2120
	Registr	ar	SEP 1 2 201	16 R ABORE	J. J.F.	20	mes)						

		1	For State Registrar	State of Maryland /	Depa Cer	rtment of H	ealth and M Death		2006	28839
	** 65	×.	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		BERTHA	BROWDY		MIN	NES	Septemb	Pay & Zoos	2300 M
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			LEVINDALE HEBREW H	IOME		BALTIMOR				N/A
.9-	Funeral		5. Social Security Number 6. Sex	IM OFF	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Coun	ace (State or Foreign (ry)
	Director	-	155-32-6187 Usual Residence of Decedent	90	Yrs.			04/22/19	16	NJ
	and and	-	10a. State 10b. County	10c. City, To	own or Los	cation			10	Od. Inside City Limits
	Marylan f show	ō	MD	N/A B	ALTI.	MORE				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	11/11	// \L_ ( I .	10f. Zip Code		10g	. Citizen of What Coun	try?
	h with	0	2434 W. BELVEDERE	AVENUE		2	21215		U.S.A	
	deat	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6	
98	or the	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give X		☐Yes 2X No	Specify:		Specify: WH	ITE
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show disal Examinar must be notified at	d by	3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	Sa Docad	lent's Usual Occupa	ation	16	6b. Kind of Business/Inc	histor
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of NOT use retired	during most of work	ing	o. Allia di Badillodallia	Sotty
212	I within iene. r then "	E O	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	REGI	STERED NU	JRSE		HOSPITAL	
	illed Hygie other	a	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
lar.	uld be Aental rksd c	ToB	LEO		BR	OWDY	CLARA		P0:	STER
Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Me		19a. Informant's Name/Relationship (Ty						City or Town, State, Zip	Code)
	ss 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. I figm 27 is marked other than "natural", or frems 23a or 28s-1 show r other traumatic avent, the Madical Examinar must be rediffed at		JOANNE MILSTONE /						, MD 21117	Chat
Ore	ges 1 t of H if its or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ F	Removal from State	tery, cren	sition (Name of natory or other plac	e)		c. Location - City or To	wn, State
Baltimore,	t. Partmen	1	4 Donation 5 Other (Specify)			IN MEMORI			RENTON, NJ	
Bal	permit. Pages 'Department of himportant: If ite any injury or of once.		21. Signature of Funeral Service Licens	(.1110)	0.0		SOL	LEVINSON	& BROS.,	INC.
.5	*		23a. Part1. Enter the disease, or compl	ications that caused the death. D	o not ent	OU KEISTE or the mode of dyin	g, such as cardiac	JAD - PIK or respiratory arres	ESVILLE, MI	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final	Alla a sa	100	120	actors	scular	Disase	Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequent			0 0,00	(000)	2.000	
	Examiner		Sequentially list conditions,	b						
	D #	ner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen-	ea ut):					
	and trans	Examin		Due to (or as a consequen-	on of):					
8760,	death certificate be executed e attending physician and d for use as the burial-transit	al E		D48 (5) (6) 23 2 60113645611	00 01).					
687	phys phys the	dlcal		d						
Box (	leath certific attending p	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Date of delive	ry
B	death a atter	ciar	in the past 12 months? 1 □ Yes 2 ▼No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
0	the che	hys	9 ☐ Unknown	9☐ Unknown				-	1	
σ,		by Physician/Me	Part II. Other significant conditions co	ntributing to death but not resultin	g in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
rds	·= ""							1 Tes	2 □ No 3 □ Prob	abfy 4 □Unknown
Vital Records,	aw as b	Completed						24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
Ä	0 4 6	mo						perform 1 ☐ Yes 2		
ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	th Check only one		
of V	d S	안	1 ☐ Yes → No		Outpatier/		4 arrursing no		ce 6 □Other (Specifi	1)
טע		on:	27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Infury	Wor		28d. Describe how	intury occurred	
Sio	ent eath or:	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	form et		Yes 2 □No	28f Location (Stre	eet and Number or Rura	I Route Number
Division	o afte o	Certification:	4 Homicide determined	building, etc. (Specify)	i, iaiiii, sii	eer, ractory, onice		City or Town,	State)	, riodio ridinibol,
_	Hospital 4 hours a Funeral tely filled	SalC		rsician: To the best of my knowle						
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	опе)	iner: On the basis of examination and manner stated.	and/ULM	29c. Licens			d. Date signed (Month,	
	To To	-	29b. Signature an Line of partifier	1/2		_ 250. Licens	777/			
	4		rune fre	omeloted source of death //s-	00) /7	S V	C310	/ 2	ah empe	77,000
	10		Dobo // los he	ompleted cause of death (ftem 23	zu (1908,	() R. 1.	Kdoso	Ale	B. Hol	HZ1215
( 5)	St	te	31. Date filed (Month, Day: Year)	32. Registrar's Signature	S. C.	Angel "	-بدور ا	1	110.1	
	Regist		OLP 1 %	LUUU A ASSESSA S	13°					

		•	For State Registrar	State of	f Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M	lental Hyg	jiene 2	006	28840
10			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		James Needham								Septemb	er 8	3, 200	
	Examin	er	4a. Facility Name (If not institution				4b. City, 7						unty of Death	
			Anne Arundel Me  5. Social Security Number		7. Age (In yrs.	last hirthday)	If Under		If Under		8. Date of Birth	3	e Arun	nplace (State or Foreign
754	Funeral Director		217-30-6910	1-25M 2□F	71	Yrs.	Months	Days	Hours	Min.	(Month, Day 01/21/	, Year)	DC Coi	intry)
			Usual Residence of Decedent								02,22,			
	arylan show	<u>.</u>	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director		Arundel	Riv	ra	401 7	0.1	_					
	with th	급	10e. Street and Number				10f. Zip						of What Co	untry?
	eath	Funeral	563 Poplar Driv		dent Ever in U	S. 13.	211 Was Deced		spanic Ori	igin? (Spe		USA 14.	Race - Amer	ncan Indian,
	r Itan	표	1 Never Married Married	Armed Fo ied 1 ☐ Yes	rces? 2.D.No						ecify Yes or No- Rican, etc.)		Black, White	e, etc.
9	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e 1		1□Yes 2	No	Specify:			Sp	ecify: Whi	te
2	72 ho	Completed	15. Decedent (Specify only highes	's Education		(Give	dent's Usua kind of won	k done d	luring mos	st of work	ing	16b. Kind	of Business/l	ndustry
2	hen.	du	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us					Const	ructio	on
7	ljed v dygie ther t		12 17. Father's Name (First, Middle,	l ast)		Sneet	: Meta	T MC			e (First, Middle,	Maiden Su	тате)	
aryland 21215-0036	d be i	Be C	John Needham	,							tockett		,	
<u> </u>	Shoul nd Me mark mati	ပ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	ınd Numbi	er or Rura	al Route Numbe	r, City or To	own, State, Z	lip Code)
2	nd 2		Dorothy Needham	Wife		563	Poplar	r Dr	ive F	Riva,	MD 211	40		
altimore,	S 1 a		20a. Method of Disposition			Place of Dispo	sition (Nam	ne of ther place	9)		Date	20c. Locat	tion - City or	Town, State
Ē	Page Tent of Int: If		1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (S		State	esapea					Sep 11   2006	Belts	ville,	Maryland
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, Ira M.dical Exemiliar must be notified at ODGs.		21. Signature of Funeral Service	Licensee	MALYL	12 0		lon a	nd Fu	inera.	l Alterna Orive Ba			ryland
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that c	aused the deat								120, 110.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1		Canc	en							Onset and Death
1 6	/Medical		resulting in death)	a. Due to	or as a conseq									monte
1	Examiner		Sequentially list conditions,	b										0,100
	D #	Iner	if any, leading to immediate cause. Enter Underlying	Due to (	or as a conseq	uence of):								
	icate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	neuce of).								
8760,	be ey	a E				201100 01,1							3	
687	icate phys s the	edical		d										
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna		<b>-</b>					230	I. Date of deli	very
œ.	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	irth 2 🗌 Feta ant at time of d		∃Ectopic pre ∃ Other <i>(sp</i> e						Month	Day Year
0	t the by the tache	hys	9 ☐ Unknown	9□ Unkno	own									
S, F	ss tha	<b>by</b> Р	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	inderlying ca	ause give	n in Part	I.				the cause of death?
ord	equir en si ould 1	ted									1,5%	es 2□1	No 3□ Pro	obably 4 Unknown
မင် မင်	law r	Completed									24a. Was autop	sy	prior to d	topsy findings available completion of cause of
<u> </u>	The page	Con									perfor	med? 2 No	death? 1 ☐ Yes	20 No
Division of Vital Records, P.O. Box	Physicien: r this certificatal director, i	Be	25. Was case referred to medica examiner?					Oth		e of Deat	h (C <i>heck only o</i> i	ne)		
<u></u>	Physi this c	2	1 Yes 2 No			ER/Outpatie			4 🗀 141		me 5 Resid			cify)
n	fing F	lon	27. Manner of Death  1 Natural 5 Pendir	9	th, Day Year)	28b. Time o Injury	M Z	8c. Injury Work	rat ∢? Yes 2. [[		Zou. Describe il	low injury o	ccurred	
Sic	Attending or death.	Icat	2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	ome farm st					28f. Location (S	treet and N	lumber or Ru	ral Route Number,
<u>≥</u>	lor A after Dire	Certification:	4 ☐ Homicide determ		ng, etc. (Speci			, 0,,,,,			City or Tow			
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerat Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifyir (Check only 2 Medical one)	ng Physician: To the Examiner: On the b	best of my kno asis of examina ner stated.	owledge, deal ation and/or in	th occurred anvestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the ored at the time, or	ause(s) and pla	nd manner as ace, and due	stated. to the cause(s)
	orthin orthin omple	Me	29b. Signature and title of certifie			^	290	. License	e number			29d. Date s	signed (Monti	n, Day, Year)
	- S - 0		> VLe.	~ 8 11	- M	J		20	05	120	,	500+	em be	9 2006
	1		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)	7	- / /	,		1	0.71 4 7	- 9 2006 5, MD 2149
	10		Kenn 8	inopt 1	10	900	Ben	991	re p	000	#300	Ano	napoli	5, MD 2149
E.	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ature	0.0	/				-	1	,

Registrar

			For State Registrar		State o	of Maryl			nent of F cate of		Mental Hy	giene	2006	28841
			1. Decedent's Name (Fin	rst, Middle, Li	ast)			-			2. Date of De	eath		3. Time of Death
	Physici /Medio		Alice Han	son Ne	va						Septe	mber	8, 2006	1:03P M
	Examin		4a. Facility Name (If not	înstitution, gi	ve street and nu	mber)		4b.	City, Town, o	r Location of De	ath	4c. C	County of Death	
			Suburban						ethesc				ontgome	
	Funeral Director		5. Social Security Number 475–14–149		Sex 1☐M 2∭TF	7. Age (In )	yrs. last birth		Inder 1 Year oths Days	If Under 24 H Hours M	n. (Month, D	rth ay, Year)	Cou	place (State or Foreign
1			Usual Residence of Dec								Mar. 1	3, 19	024 Cold	orado
	yland how		10a. State 10b	. County		10c	. City, Town	or Location	1					10d. Inside City Limits
	Ba-f e	cto	Maryland M	ontgom	ery	F	otoma	С						1 □ Yes 2√□ No
	or 24	Director	10e. Street and Number					10	f. Zip Code			10g. Citizo	en of What Cou	intry?
	s 23a	rai	10851 Glen	Road	10.14/ 0			10 111 .	20854				ed Stat	
	ter de	Funeral	11. Marital Status 1 □ Never Married	2Ñ Married	12. Was Dec Armed Fo 1 ☐ Yes	orces?	in U.S.	If Yes	specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No orto Rican, etc.)	0- 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
936	urs af	δ	3 Widowed 4		If Yes, Gr Year or D	ve		1 □ Y	es 2∑ No	Specify:		5	Specify: Wh	ite
5-0	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28a-f ehow event, i're Medical Examinar miss te redified at	Completed	15.	Decedent's E	Education rade completed)		16a. (	Decedent's	Usual Occup	pation during most of w	orkina	16b. Kind	d of Business/Ir	
21	ithin Ber	npie	Elementary/Secondary		College (	1-4or 5+)		life. DO N	OT use retire	d)	orking			
2	led w tygier her th	S	17 Fathada Nama (Final	Adiedelle I ee	4		Ho	memak	er	40. 14-15-1-1	(5:		n Home	
anc	ntal Hed of	Be	17. Father's Name (First) Harold Hai		1)						ame (First, Middle	, Maiden S	oumame)	
Σ	2 should and Men le marke aumatic	၉	19a. Informant's Name/		(Type Print)		19h	Mailing Ad	trass (Street		s Blegen Rural Route Numb	ner City or	Town State Zi	Code)
2	and 2 seath ar n 27 le		Dr. Frankl:			sband	1	_		ad. Pot	omac. Mai			30-6
9	is 1 a of Heel		20a. Method of Dispositi	on		20	b. Place of I	Disposition		ce) Sor	t Date		ation - City or T	
<u> </u>	Pages hent of I ant: If Its ary or o			4 Donation 5 Other (Specify) Saron Cemetery 2006 Aitkin, Mi										
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be positived at once.		21. Signature of the rai	Service Lic	nsee	- S.S.		Be th	e and Addre	ss of Facility R	obert A.	Pumpl	rey Fu	neral Home/
	805 # 9	_	1	حال	ree!			Beth	esda,	Marylan	1 20814-	-3501	, MISCO.	nsin Avende
			23a. Part1. Enter the dis shock, or heart fail	ure. List only	nplications that of y one cause on e	caused the c each line.	death. Do no	ot enter the	mode of dyir	ng, such as card	ac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	100	_ a	Dila	tol	Ca	50/10	myopa	the			Onset and Death
	/Medical Examiner		resulting in death)	•	Due to	(or as a con	sequence of	):	,	1	. /			1
		er	Sequentially list condition	ns, iate	b. Due to	(or as a con	ra l sequence of	Kredi	15974	attan				C mon D
	uted d ansit	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	~ ~										
o o	sate be executed by sicien and the burial-transit	Exa	resulting in death) Last		Due to	(or as a con	sequence of	):						
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ج ق		Med	IF FEMALE:											
1,03 pm P.O. Box 6	The law requires that the death certifit are hes been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pred in the past 12 month			ointh 2 🗆 F	Fetal death		oic pregnancy	,		23	3d. Date of deliv Month	ery Day Year
0.0	t the de by the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4⊟Pregr 9⊟ Unkn	nant at time own	of death	5 ∐ Othe	r (specify) _					
Q.		/ Ph	Part II. Other significant	conditions	contributing to d	eath but not	resulting in	the underly	ing cause giv	en in Part I.	23e. Did	tobacco use	e contribute to t	he cause of death?
o ds	quires n sign uld be	d b									10	Yes 2□	lNo 3□Proi	oably 4 Onknown
9/8/00	aw require is been si 2 should b	Completed									24a. Was	an	24b. Were auto	opsy findings available
350 He	The lavate hes	E									auto perfo	ormed /	prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
ital	iiclen: Th certificete rector, pag	Be C	25. Was case referred to examiner?	medical		<del>ocoo</del> n	- 1 <del>- 1</del>			26. Place of D	eath Check only		10 165	2 140
ತೆ <b>ಕ್</b>	Physic this ce al dire	မ	1 ☐ Yes 2 ☑ No				2 ER/Outp	atient 3	DOA Oth		Home 5 ☐ Resi	dence 6 l	□Other (Specia	<b>(y</b> )
Neva-	ding P h. After ( funera	lon:		Pending		of Injury th, Day Yea	r) 28b. Tir r) Inj	ury	28c. Injur Wor		28d. Describe	how injury	occurred	
	Attending Physicien: r death. sctor: After this certifica by the funeral director, i	icat	2 Accident 3 Suicide 6	investigation     Could not I	00 - Disease	of Injuny - 4	At home, farr	M street to		Yes 2 □No	28f. Location (	Stroot and	Alumbar or Dua	al Route Number,
S S	al or Attend after death I Director: A	Certification:	4  Homicide	determined	buildi	ng, etc. (Sp	ecify)	ii, siieei, ia	ictory, office		City or To	wn, State)	INDITION OF HUR	ar Houte Number,
Alle	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1	Certifying P	hysician: To the	best of my	knowledge,	death occu	rred at the tin	ne, date and pla	ce, and due to the	cause(s) a	nd manner as s	tated.
· Strafferman	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai	(Check only 2 one)	Medical Exa	miner: On the b	asis of exan ner stated.	nination and	or investig	ation, in my o	pinion, death oc	curred at the time,	date and p	place, and due to	o the cause(s)
		Σ	29b. Signature and title	of certifier	4).	,	1		29c. Licens			29d. Date	signed (Month,	Day, Year)
	7		Na	Perm	Dor	perg	MA	>	V16	360		4	18/2	2006
_	20		30. Name and address of			-			Drive	#200	Rotharda	MD	20817-	1830
	Sta	te.	Samuel Go. 31. Date filed (Month, Da			0410 legistrar's Si	ignature	A		π <b>200</b> ,	Bethesda,	עוני (	2001/-	.030
	Registr		SEP	1 2 200	16	1388-3 ad	Jr. 1	TRACE	P					

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. amend item 25 per doc g859 9-12-06 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 28842 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Dolores Ohlendorf September 3, 2006 11:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3316 Trellis Lane Abingdon Harkord 8. Date of Birth (Month, Day, Year) NOV. 16, 1 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 ☐ M 2 ☐ VF 212-26-2455 78 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or iteme 23s or 28s-f show yent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3316 Trellis Lane 21009 u.s.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 end 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: if item 27 ie marked other then "natural", or ite ury or other treumatic event, the Medical Examinal 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. Specify: White 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 Coltege (1-4or 5+) Financial Co. Clerical Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Donald Prendergast Clara Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas C. Ohlendork (son) 3316 Trellis Lane, Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Most Holy Redeemer 9/7/2006 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Rd., Bel Air, MD 21014 21. Signature of Funeral Service Licensee reller Busin a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ipe dementia Immediate Cause (Final disease or condition resulting in death) **Physician** emonths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): physicien a s the burial-O. Box 68760 Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) as been signed by the 2 should be detached 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown ropares is Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ o page heart disease 1 ☐ Yes 2 No Division of Vital director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident s effer dea... el Director: Afr 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined within 24 hours efter de To the Funarel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner space. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 0030717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St.. Baltimore. Md. Alicia Cool, M.D., 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State SEP 1 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#23a perPHYS C859 9/12/06 WS
State of Maryland Pepartment of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month K. 57PM R. Parker Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lare CHIMORE Il Under 24 Hrs Social Security Numbe 8. Date of Birth (Month, Day, Year) Oct. 2,1917 9. Birthplace (State or Foreign Country) Maryland 7. Age (Inlyrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Min 88 217-18-1721 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or iteme 23a or 28e-f show event, the Medical Examiner must be notified at Chase Baltimore 1 ☐ Yes 2 ☐ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 143 Cowhide Circle U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene.

If Item 27 1e marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sales Lady Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DiBlasi Joseph Rotondo Frances ပ Parker, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Parker (Son) 143 Cowhide Circle Baltimore, Maryland 21220 permit. Pages 1 and Depertment of Health important: if Item 27 any injury or other trugge. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem 9/5/06 Baltimore, Maryland 21. Signature of Fyheral Service Licensee McCully-Polyniak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 21230 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line.

CARDIAC ARREST. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WSi /Medical Due to (or as a consequence ol): Examiner (20 min.) GASTRIC ACID ASPIRATION: ACONAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physicien and the buriel-transit To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s 1 Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this After this funeral of 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY bruce o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person SelingER Frank DR. Stephen 31. Date filed (Month, Day, Year) 2005 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

SEP

JOSEPHINE

6034

State of Maryland / Department of Health and Mental Hygieney 28845 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MONY 1030AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltrura John (ante (ove If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09/23/1918 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 225-18-5398 87 VA Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23e or 28a-f show other traumatic event. The Madical Expedition must be notified at Yes 2 No Director MD BALTIMORE TURNER STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 219 CHESTNUT STREET 21222 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? XM∑Yes 2 □ No If Yes, Give Year or Dates: 1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK à 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be tiled within: Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "tany njury or other traumatic event, II s MAG 20128. Elementary/Secondary (0-12) College (1-4or 5+) FOUNDRY WORKER BETH STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANTHONY POWELL ALICE MARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 APT. G. SUGARWOOD CIRCLE, ESSEX, MD 21221 ANTHONY POWELL, III, /SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/14/06 MIDDLE RIVER, MD HOLLY HILLS <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC ame 1701 LAURENS ST., BALTO., MD 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, freart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lind **Physician** disease or condition resulting in death) Veous /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760. certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 dunknown Completed pertensia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 1 Tes Yes Hospital or Attending Physician: 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 🗌 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? tripled on Shoelace on 5 27. Manner of Death 28b. Time of Certification: After injury 1 Natyrat 5 Pending death. Unkow PM 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 219 Chestrut St., Turver State 4 - Homicide 219 thin 24 hours a Wher 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vew Circle State SEP 1 2 2006 Registrar

	4.50	1 - State Amend item#1 Registrar  1. Decedent's Name (First, Middle,	State of Maryland ,perMD,g859,9/12/06	TT Cei	tificate of L	ealth and I Death		g. No. Z U U	6 28846			
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Exam		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Deatl	13	4c. County of E	eath			
Funovi		5. Social Security Number	3. Sex 7. Age (In yrs. Is	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	CAY	Birthplace (State or Foreign			
Funera Directo		218-82-5662	1⊠M 2□F 45	Yrs.	Months Days	Hours Min.	(Month, Day, 03/17/	1961	Country) MD			
and we		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits			
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or 28:	Director	10e. Street and Number			10f. Zip Code		. 10	g. Citizen of What	Country?			
s 23a	erall	804 SHOWELL CT.	12. Was Decedent Ever in U.S	2 12 1	21202	opposio Origina (C	positi. Van as Na	USA	mencan Indian,			
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Mudical Exercitistriust by nutified at	by Funeral	11. Marital Status  1   Never Married 2 Married  3   Widowed 4   Divorced	Armed Forces?		Mas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2(X)No	n, Mexican, Puert  Specify:	o Rican, etc.)		/hite, etc.			
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Aental	To Be	JAMES D. PEACOCI	ζ			MATTIE	C. LEACH	<del>I</del>				
Maryland d 2 should be file th and Mental Hy l'is marked oth traumatic event		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	g Address (Street a		iral Route Number,		e, Zip Code)			
e, N 1 and Health em 27 ther tr		VANESSA WOOD  20a. Method of Disposition	20b. Pl		7 SHOWELL sition (Name of	CT., BA	-	MD 2120				
MOT Pages nent of nt: if it		1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	3 □Removal from State	metery, crer	natory or other place	1			ONNELL ST.			
ing State in		21. Signature of Funeral Service Li	1		CEMETER: Name and Addres		9/2006 SLEY CHAV					
		Meslay C	parts.		2007-09	EASTERN	AVE., BAI	TIMORE,				
8760, rate be executed Examinity Examination and process the purity-fransit	1	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Apply that initiated events resulting in death) Last	a. Acual Blue to (or as a consequence of the conseq	ence of):  cultivated by the control of the control	Los Erosia Llung	anei Came	nia.	BALTIMORE, MD 212: HAVIS, JR. FNRL. HM.				
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Division  To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  Certifying  2 Medical E	Physician: To the best of my know xaminer: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tim restigation, in my op	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)			
To the To the To the comp	×	29b. Signature and title of certifier	14)		29c. License	number	29	d. Date signed (Me	onth, Day, Year)			
		round	4. BUSTE	Mg	DYC	7744	H	ugust	24,2006			
(2)		30. Name and address of person w	tho completed cause of death (Item	23a) (Type,	Print)	rutes ?	301 Str.	Paul	Place			
25710 CONT.	tate	31. Date filed (Month, Day, Year)	22. Registrar's Signal	ure A		uni	150 15	rule, il	d/202			
Regis	strar	SEP 0 1 2	006 Selection of	Ship has								

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SEPTEMBER 7, **Physician** 2006 2:50a M SALLIE PLATER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCREST HOSPICE CENTER TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4-2-1926 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 ☐ M 2 ☐ F Yrs SOUTH CAROLINA 80 Director 238-42-6737 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 Xes 2 No Completed by Funeral Director N/A BALTIMORE with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 ALHAMBRA AVE. 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) -8--0-CAREGIVER HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOSES CHERRY EMMA BOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE WEBB (DAUGHTER) 5000 ALHAMBRA AVE. BALTIMORE, MARYLAND 21212 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispesition 20c. Location - City or Town, State Pages 1 ö ☐Cremation 3 ☐Removal from State tX Burial = 5 Department of important; if any injury or once. BALTIMORE NATIONAL 9-12-2006 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation ee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of dementing Pnysician Camplications months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes: 2 No Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ØNo 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify NOSP) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 m N. St Mouro 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

			For State Registrar		State of	f Marylan		artmen tificate			and M	ental Hyg		006	28	848
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	Examin	er	4a. Facility Name (If not insti	_		nber)				Location o				unty of Death Baltim		
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	1		place (State	or Foreign
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Baltimore,	permit. Pages 1 and Department of Heall Important: if itam 2 any injury or othar once.		20a. Method of Disposition 1 X Burial 2 ☐ Crema		emoval from	State	Place of Dispo cemetery, crer			- 1				on - City or T		
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ľ	342		30. Name and address of pe	rson who cor	Greene	Tree R	ond 50	ite 1:		Balt	fimae-	c, mary	land	2120	8	
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			For State of Maryland /		tment of H				006	28849
			. Decedent's Name (First, Middle, Last)				2. Date of Deat	h Day	Year	3. Time of Death
	Physici /Medio		Richard A. Pratt				Septembe	er 9, 2	:006	4:40pm M
	Examin	er	a. Facility Name (If not institution, give street and number)		_	Location of Death		4c. County	of Death imore	
	Funeral		Greater Baltimore Medical Center Social Security Number 6. Sex 7. Age (In yrs. last by	birthday)	Towson If Under 1 Year	If Under 24 Hrs.				ace (State or Foreign
	Director		374-34-8429 <sup>1</sup> ₹ <sup>M 2□F</sup> 67	Yrs.	Months Days	Hours Min.	(Month, Day, April 2			igan
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0	er dea	Funeral	Marital Status     12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
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+ \$	D = C =		Sylvia E. Pratt Wife	32 Vi	.11age Mi	.11 Court	, Owings	Mills	, MD 2	1117
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	/Medical Examiner		Due to (or as a consequence	e of):						
		Je.	f any, leading to immediate ausse. Enter Underlying Cause (Disease or injury	e of):						25
	ate be executed thysician and the burial-transit	Examiner	nat initiated events							
30,	oe exe cian a ourial-		esulting in death) Last Due to (or as a consequence	e of):						
8760,	physic	dical	d				· · · · · · · · · · · · · · · · · · ·			
Box 6	certifi nding use as	Physician/Me	F FEMALE: 23c. If yes, outcome of pregnancy					23d. Da	te of deliver	,
B	death e ette	ıclaı	in the past 12 months?  1 Vas 2 No.  4 Pregnant at time of death		ctopic pregnancy Other (specify)					ay Year
0.9	at the by th	hys	9 Unknown							
ds, l	uires th n signed ald be de	þ	Part II. Other significant conditions contributing to death but not resulting Diancles Mellitus	in the und	lerlying cause give	on in Part I.	23e. Did tob			cause of death?
Ō	aw rec s bee 2 shou	Completed					24a. Was ar	1 24b.	Were autops	sy findings available
- R	The late happage	E O					autops perform	1ed2	death?	pletion of cause of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?				h (Check only one			
of \	Physi this c al dire	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C				ome 5 Reside			
on	ding h. After funer	tlon	17. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury Work	at ?? ∕es 2 □No	28d. Describe ho	w injury occur	100	
Division of Vital Records, P.O.	or Atten fter deat Sirector: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree			28f. Location (Str City or Town		per or Rural	Route Number,
Ц	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only 2 Medical Examiner: On the basis of examination a	Ige, death of	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the ca	use(s) and mate and place,	anner as sta	ted. he cause(s)
	thin 2. the f	Medi	one) and manner stated.  29b. Signature and title of certifier		20e Lieene			Data diam	d /ldo-sh D	- V
	\ \ \		m	)	D5	5942	2 1	9/10	1200	6
	1/		Name and address of person who completed cause of death (Item 23a	a) (Type, P	rint)	5942 T MO		111	,	
10	1	17	AULFOSTEN 6565 N CHARLES	#20	3 BAC	T mo	2120	<u>۲</u>		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	THE PERSON NAMED IN	· marco					

		•	For State Registrar	State of Maryland		rtment of H tificate of I		lental Hygier Reg. N	/       h	28850
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	liv .				2. Date of Death Month E	Day Year	3. Time of Death  / ≥ : ≥c / M
	Examin Funeral Director		×17. ×4.2694	7. Age (In yrs. las	st birthday) Yrs.	4b. City, Town, or Region If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Sept 2(c	4c. County of Death    Salting   9. Birthple County   17)   9.5	place (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  Char L	1 1	Town or Loc				10	0d. Inside City Limits 1 □Yes 2 No
	n with the 3a or 28a at be noth	Funeral Director	10e. Street and Number 3143 Sedos Will	K Dr		10f. Zip Code	03		Citizen of What Coun	itry?
920	d within 72 hours after death with the Maryland jene. r than "natural", or items 23s or 28s-f ehow the Medical Examinar must be notified al	þ		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	17	as Decedent of H	ispanic Origin? (Spenic, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: Black	
21215-0036	within 72 ene. than "na he Medic	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give k		ation during most of working	ing	Kind of Business/Inc	lustry
Maryland 2	ould be filed   Mental Hygir   Marked other	To Be C	17. Father's Name (First, Middle, Last)  Thomas J Rus	itin Sr.			Kathe		auson	
_	is 1 and 2 should be filed of Health and Mental Hyg item 27 ie marked othe other traumatic event,		19a. Informant's Name/Relationship (Typ  Doslan Peters  20a. Method of Disposition	20b. Plac	314 G	Address (Street as Street as Street as Street as Address (Street as Ad	المان الد	Dr. Wal	or Town, State, Zip  doff Md  Location - City or To	20603
<b>Baltimore</b> ,	permit. Pages Department of important: if it any injury or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Cicenses	Ar b	22.	Cemetre Name and Address	ss of Facility CY	106 Ar		We was Home
	Physician		23a. Part1 Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. cause on each line.	Do not ente	YO Re's to	g, such as cardiac		Itimore Ma	Approximate Interval Between Onset and Death
60,	Medical Examiner and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	Sicienty	Syndrus	_		
.O. Box 68760	death certifi e attending id for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	c. If yes, outcome of pregnanc 1   Live birth 2   Fetal d 4   Pregnant at time of dea 9   Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
Δ.	signed d be de	ρ	Part II. Other significant conditions cont	nbuting to death but not result	ing in the un	derlying cause giv	en in Part I.		o use contribute to th	ne cause of death?
of Vital Records,	The ate h page	Completed						24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
ξ	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 Unpatient 2 E	R/Outpatient	3□ DOA Oth	0.0	n (Check only one) me 5 ☐ Residence	6 □Other (Specifi	w)
ion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	~	8b. Time of Injury	28c. Injun World		28d. Describe how in		<u>, , , , , , , , , , , , , , , , , , , </u>
Division	tai or Atters as after de ei Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Street City or Town, Sta	and Number or Rura ite)	l Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exeminone)	cian: To the best of my knowl er: On the basis of examinatio and manner stated.	ledge, death on and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
	To With	Σ	29b. Signature and title of certifier  A/(	Tuf		29c. Licens			Date signed (Month, l	
0	4		30. Name and address of perso who con Alice (Month, Day, Year)	nple ed cause of death (Item 2	p /	Print)	/ Mand	Sign	Mary la	·d
	Sta Registr			106 Legger	St de	books			,	

	Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Deat
_	-1 -11						Month	Da		
4	John Rehbei  1. Facility Name (If not institution, give st.			4h Ci	y Town of	r Location of Deat	Sept.		2006 c. County of Deat	10:51A
4d.	900 Cathedral St.				ltimo				,	N/A
5.	Social Security Number 6. Sex		(In yrs. last birthd	y) If Unc	ler 1 Year	If Under 24 Hrs	8. Date of Bir	th Your	9. Birtl	nplace (State or For untry)
	218 68 0895	M 2□F 5	51 Yrs	Month	s Days	Hours Min.	May 5,	195	55 Texa	as
-	sual Residence of Decedent  Da. State 10b. County		10a Cihr Toum o	Location						10d. Inside City Lin
1										1 Tyes 2
10			Baltimo		7in Code			10a C	itizen of What Co	
1		Ant 200	1	101.		11		. vg. c		
11		2. Was Decedent Ev		3. Was De			Specify Yes or No	)-	14. Race - Ame	
•	1 Never Married 2 Married 3 Widowed 4 Divorced					Specify:	to Hican, etc.)			hite
	15. Decedent's Educa	ation	16a. De	cedent's U	sual Occup	ation	urkina	16b. l	Kind of Business/	Industry
	Elementary/Secondary (0-12)		- In	e. DO NOT	use retired	duning most of we	irkii ig			
Ш		2	Acc	untir	ng Mar					ompany
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1										ip Code)
20	•	moval from State	20b. Place of Di cemetery,	sposition (fi crematory o	lame of r other plac		Date	20¢. L	_ocation - City or	Town, State
	'4 □ Donation 5 □ Other (Specify)	4)	1							
2	1. Signature of Funeral Service Licenses	De M	101442							
2	23a. P m 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to cause on each line	he death. Do not	enter the m	ode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	mmediate Cause (Final	Myora	e odia	0 1	in fa	retror				Onset and Death
re	esulting in death)	Due to (or as a	consequence of).		,			-		16
S	Sequentially list conditions, b.	Type	i D	95C	125					4040
CC	any, leading to infinediate lause. Enter Underlying Cause (Disease or injury	Dur to (or as a	consequence or):							
th re	hat initiated events c. esulting in death) Last	Due to (or as a	consequence of):							
	U.									
11				3∏Ectonic	nreanancy	,				
	in the past 12 months? 1 🗆 Yes 2 🗀 No	4 Pregnant at ti				·			Month	Day Year
	9 Unknown									
P	art II. Other significant conditions cont	ributing to death but	not resulting in th	e underlyin	g cause giv	en in Part I.				
-								185 4	ZINO SPATE	obably 4 Dollkin
.   _							auto	psy	prior to o	topsy findings available completion of cause
										2 No
	examiner?	osnital:		77.72.2	Oth	OC.				
	I Tes ANO	1 🗀 Inpatien			77.75	4   Nursing	-			cify)
	Natural 5 Pending	(Month, Day	Year) Inju					,	,	
	3 Suicide 6 Could not be			street, fac	ory, office	- 40	28f. Location (	Street a	and Number or Ru	ıral Route Number,
	· C riomoldo	Dundang, oto.	(0,000.))							
		er: On the basis of e	examination and/o							
	29b. Signature and title of certifier	, P			29c. Licens	e number		29d. D.	ate signed (Monti	h, Day, Year)
	1/hut 5x	120			D45	811		9-	12-06	
3				pe, Print)						
	6535 N. Cha	iles SH	# 40	N	. 72	12502	LAN	2	1204	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MID  N/A  10e. Street and Number  900 Cathedral St.  11. Marital Status  1	MD N/A  10e. Street and Number  900 Cathedral St. Apt. 205  11. Marital Status  1	MD N/A Baltimor  10e. Street and Number  900 Cathedral St. Apt. 209  11. Marital Status  1	MD N/A Baltimore  10e. Street and Number 900 Cathedral St. Apt. 209  11. Marital Status 1   Never Married 2   Married 3   Widowed 4   Qonorced 15. Decedent's Education (Specify only highest grade completed)   Elementary/Secondary (0-12)   College (1-4or 5+)   C	MD N/A   Baltimore   106. Zip Code   107. Zip Code   108. Zip Code   108. Zip Code   108. Zip Code   109. Z	MD   N/A   Baltimore   106. Street and Number   900 Cathedral St. Apt. 209   21201	No.   Street and Number   106. Zip Code   21.201	ND   N/A   Baltimore   106, Zip Code   109, C   21201   101, Zip Code   200, C   21201   101, Zip Code   21201   101, Zip Code   21201   102, C   21201   103, Marital Status   1   Never Married   2   Married   2   Married   2   Married   2   2   Was Decadent Ever in U.S.   12   Was Decadent of Hispanic Origin? (Speedy Yes or No-Index of Code)   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   109, C   200, No.   2	Title Stress and Number   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 209   10f. 2g Code   10g. Cathedral St. Apt. 200   10g. Cat

State of Maryland / Department of Health and Mental Hydiene 2006

			1 - For State Registrar	State of Marylan	d / Depa	artment of tificate	of Health and of Death		g. No.	6 28852			
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las ANTHONY J.					2. Date of Death Septem		3. Time of Death 11:30 Au			
1	Examir		4a. Facility Name (If not institution, give Gilchrist Cer				wn, or Location of Deat <b>TOWSON</b>	h	4c. County of Dea Balt	imore			
	Funeral Director		5. Social Security Number 216-16-8671 12	7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Months E	Year If Under 24 Hrs Days Hours Min.	8. Date of Birth	9. Bir Ma	thplace (State or Foreign ountry) aryland			
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits			
	Maryl a-f sho	tor	MD Balt	imore	Park	ville	!			1 ☐ Yes 2 XNo			
	h with the 23a or 28a	ai Direc	10e. Street and Number 2314 Putty Hil	l Avenue		10f. Zip Co	21234	10	g. Citizen of What C	ountry?			
960	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examilinar must be mutilied at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent f Yes, specify	nt of Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify:	erican Indian, le, etc. hite			
21215-0036	within 72 h ene. than "natu ha Medical	mpletec	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) Collège (1-4or 5+)	(Give life, L	tent's Usual ( kind of work ( DO NOT use ( Orema	done during most of wor retired)	<sup>King</sup> B		Gas and Company			
Maryland 2	should be filed and Mental Hygic marked other umatic event, I	Elementary/Secondary (0-12) College (1-4or 5+)  Boundary (0-12) College (1-4or 5+)  Boundary (0-12) Sold Foreman  Foreman  17. Father's Name (First, Middle, Last)  Peter Russo  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S											
Mary	d 2 shouth and h		19a. Informant's Name/Relationship (7) Lois Russo-Spot			-	Treet and Number or Ru		-				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ances.		20a. Method of Disposition  1 Mag Burial 2 Cremation 3 4 Donation 5 Other (Specify	Oc. Location - City or									
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility EVANS CHAPEL OF ME 8800 Harford Road-Parkville, MD										
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition										
1	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					d			
	cuted id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ience of):								
68760,	tificate be executed g physicien and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	ience of):								
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□	Ectopic pregi Other (speci			23d. Date of de Month	livery Day Year			
rds, P	quires that n signed b uld be deta	by	Part II. Dther significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying caus	se given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?			
Division of Vital Records,	The law require sete hes been six page 2 should b	Completed						24a. Was an autopsy perform 1 ☐ Yes 2	ed? prior to death?	utopsy findings available completion of cause of			
25. Was case referred to medical examiner?								)					
ot	Phys or this oral dir	1; To	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Softence of Injury at Work?  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  28c. Injury at Work?						city) NOSPICE			
sion	tending leath. tor: Afte the fune	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury	М	1 ☐ Yes 2 ☐ No						
Divi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	4 Homicide determined	building, etc. (Specify	·)			City or Town,	·				
	ne Hospi 24 hou ne Funer sletely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the occurred of th	the time, date and place my opinion, death occu	red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)			
	To ti To ti comp	Ň	29b. Signature and title of certifier	000			boo 519	7/6	d. Date signed (Mont	h, Day, Year)			
10	X		30. Name and address of person who c		23a) (Type,	Print)	2000		7, 1,	2006 noe MD 2120			
	Sta		31. Date filed (Month, Day, Year)	A. Registrar's Signat	ture S	U, (V	VU 103 ST	PPE 20	03 Kaltu	nor M1) 2120			
	Registr	20.0	CED 1 9 200	n 1575 C. ca c	1.57313	The state of the s							

			1 - For State Registrar		of Marylan	d / Depa	artmen rtificate	t of H e of L	ealth a	and M		Reg. No.	2006	28853	
	Physici		1. Decedent's Name (First, Middle Gerald Le		is						2. Date of De. Sept. 7		06 Year	3. Time of Death 10:36 Am	
	/Medic Examin		4a. Facility Name (If not institution Southern Mary	, give street and nu	mber)		4b. City,		Location o	of Death			County of Death	George's	
	Funeral Director		5. Social Security Number 230 46 8857	6. Sex 1 → M 2 □ F	7. Age (In yrs. 65	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Aug 5,	h v. Ye <i>ar)</i> 194	Cou	place (State or Foreign Intry) Sinia	
	yland now		Usual Residence of Decedent  10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. Cit	y, Town or Lo			-					10d. Inside City Limits	
	Ne Mar 28a-1 al	ector	Maryland Prince	e George'	S	Мс	rning 10f. Zip		<del></del>			10- 0:	zen of What Cou	1 ☐ Yes 2 No	
	h with	a Dir	4501 Morgan	Road			101. 210		746			•	ted Sta	•	
936	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married XX Marr 3 □ Widowed 4 □ Divorced	Armed F	edent Ever in U. orces? 2 TNO vel X Dates:		Was Deced If Yes, spec 1 ☐ Yes		ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: Whit	ican Indian, , etc.	
Baltimore, Maryland 21215-0036	within 72 hor ane. than "naturi	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	life.	dent's Usua kind of wor DO NOT us	rk done d se retired	during mosi )	t of worki	ng		nd of Business/li		
land 2	ld be filed vental Hygie ked other ic event, it	To Be Co	11th 17. Father's Name (First, Middle, Carl Richard	,		Au	LO /IR	ecna	18. Mothe		(First, Middle, Southar	Maiden			
Mary	alth and Malth a		19a. Informant's Name/Relations Sharon Richard											p Code)	
imore	Pages 1 ament of He ant: If Item ury or other	20a. Method of Disposition  1 \( \text{\text{Nemation}} \) 2 \( \text{\text{\text{Cremation}}} \) 3 \( \text{\text{Removal from State}} \)  4 \( \text{\text{Donation}} \) 5 \( \text{\text{Other}} \) (Sept (Specify)  20b. Place of Disposition (Name of cemterly, crematory or other place)} (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place)} (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory or other place) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterly, crematory) (Name of cemterl											aryland		
Balt	Departition Depart	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 C Alexandria Ferry Road, Clinton, MD 20735													
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Malignant Ventricular Arry Humin											Approximate Interval Between Onset and Death	
	/Medical Examiner	_	resulting in death)		(or as a conseq Chemic (or as a conseq	uence of):						e, City or Town, State, Zip Code) e, MD 20746  20c. Location - City or Town, State Clinton, Maryland .1 Home, Inc 6633 Old .nton, MD 20735  rest, Approximate Interval Between			
8760, E	death certificate be executed e attending physicien and ad for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		(or as a conseq (or as a conseq		tiry		'seas	E					
P.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: N/A 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregna birth 2 Peta nant at time of d lown	I death 3	A Ectopic pr Other (sp					2	23d. Date of deliv		
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to		se contribute to	the cause of death?	
Reco	The law resete has bee page 2 sho	Completed									24a. Was autop perfo 1 🗆 Yes	an sy rmed? 2012 No	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of	
Viita	Physician: The la r this certificete ha. ral director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2 🗆	ER/Outpatier	nt 3□ DC	Othe	0.00		(Check only o			4.)	
Division of Vital Records,	To the Hospital or Attending Phy within 24 hours effect death. To the Funeral birector: Affer this completely filled in 3y the funeral d	Certification; T	27. Manner of Death 11. Natural 5 Pendin 2 Accident investic 3 Suicide 6 Could	28a. Date (Mor		28b. Time o Injury	f 2	8c. Injury Work 1 🔲 `		No	28d. Describe l	iow injun		ral Route Number.	
Ō	pital or A ours efter erat Direc filled in 39		29a. Certifier 12 Certifyin		ling, etc. (Specif	y)			- data an		City or Tov	m, State,	)		
	To the Hospital within 24 hours (To the Funeral completely filled	Medical	(Check only 2 Medical one)	Examiner: On the I	pasis of examina nner stated.	tion and/or in	vestigation	, in my of	pinion, dea	th occurr	ed at the time,	date and	place, and due	to the cause(s)	
	To Yeith	~	29b. Signature and title of pertition	4					FII8	2		29d. Dat	e signed (Month), $\frac{3}{7}/\frac{7}{2}$	CC 6	
-	6		30. Name and address of person Felton And	DICCOM IA	se of death (Item	n 23a) (Type, 400 L)	Print)	the	Rd	# 35	20 FT	. WA	SHINGTON	006 1, MO 20744	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1	2 2006	Registrar's Signa	iture	frank.	1							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certifi	cate of Death		Reg No	200					
Phýsician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Lisa Roy	√e			Date of Death Month Day September 7, 2		3. Time of Death 1728 hrs				
un.	4a. Facility Name (if not institution, give s Shady Grove Hospital	treet and number)	4b City, Town, or Rockville		40	County of Death					
Funeral Director	5 Social Security Number 239–23–8957 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Yea  Months Day  Yrs	r If Under 24Hrs. 8 s Hours Min.	Date of Birth(MM March 10	DD/YYYY) 9. Birth , 1974 Foreign Cou	place (State or <b>Castonia</b> ntry) <b>NC</b>				
e Maryland or 28a-f show any fred at once.	Usual Residence of Decedent  10a State  10b County  MD  montgome	10c. City, Tow	or Location Sermantown				10d Inside City Limits 1 XYes 2 No				
th the Maryland 23a or 28a-f sho notified at once. Il Director	10e. Street and Number 19902 Crystal Roo	ck Drive Apt#10	10f. Zīp Code 20874		,	izen of What Count SA	ry?				
fter death wi I", or items er must be a y Funere	1 Never Married 2 Married 3 Wildowed 4 Divorced If 15 Decedent's Education (Specify only	highest grade completed) 16a	13. Was Decedent of His If Yes, specify Cubar  1 Yes 2 No a. Decedent's Usual Occupa during most of working life	specify: tion (Give kind of work	an, etc.)	14 Race - Americ White, etc.  Specify Kind of Business/In  Commercia	te				
5-0036 led within 72 hours a Hygiene other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)	Accountant			Construct					
21215-0036 uld be filed within 72 Mental Hygiene marked other than te event, the Medical To Be Comple	17 Father's Name (First, Middle, Last)  Larry Aiken			18.Mother's Name (Fi Lisa E	rst, Middle, Maider Bumgardne						
and 2 should tealth and Mer tem 27 is man traumatic ev	19a. Informant's Name/Relationship (Type Lisa Bumgardner /	Mother	9b. Mailing Address (Stree 320 East G10	endale Ave	Mount H	olly,NC 2	8120				
MOFE Pages 1 tent of H int: If i	4 Donation 5 Other Specify	Removal from State Hillo	e of Disposition (Name of ce latory or other place)  rest Gardens  22. Name and Addres	9/13		Location - City or T					
Balti permit. Departm Importe	21. Signature of Fineral Service License	eral Home ] 1timore MD	21230	Approximate Interval							
Physician /Medical Examiner	dical since List only one cause on each line.										
red nsit	cause. Enter Underlying Cause	ie to (or as a consequence of):									
cuted nd transit	events resulting in death) Last Du	e to (or as a consequence of)									
760, icate be executed the burial - transit		AMENDED			22	ld Date of delivery					
Box 6876 death certificate the attending phy def for use as the hysician/M	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown	23c. If yes, outcome of pregnand Live birth Pregnant at time of death Unknown		Ectopic pregnancy		Month Da	ay <b>Y</b> ear				
<b>□</b> e the e <b>□</b>	Part II. Other significant conditions of		ting in the underlying cause	given in Part I		use contribute to the	ne cause of death?				
Division of Vital Records, P.O. and or Attending Physician: The law requires that this rish after death and the restrictor. After this certificate has been signed by lied in by the funeral director, page 2 should be detach entification: To Be Completed by Pertification: To Be Completed by P	1,				24a Was an autopsy performed?		opsy findings available impletion of cause of				
tal Rec	25 Was case referred to medical		26.Place	e of Death (Check only	1 Yes 2 1	No 1 Yes	2 No				
Vital hysician this cert I directo	augminas?	spital. 1 Inpatient 2 🗸 ER		Other Nursing H	p- 9	ence 6 Other:					
on of Vending Phath or: After the funeral the funeral thion: Tellion: Tellion or the funeral thing the funeral thing or the funeral thi	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation	(Month Day Year)	445		d Describe how in iver auto auto						
Division o spital or Attending tours after death neral Director: Affilled in by the func Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home (Specify) Major Road /			or Town, State)		al Route Number, City				
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Corr	(Check only one) 2 Medical Examiner: C	To the best of my knowledge, on the basis of examination and/ond manner stated	death occurred at the time, d	ate and place, and du	e to the cause(s) a	nd manner as starte	d				
Me.	29b. Signature and title of certifier	ell Mo	29c, Licens			Date signed (Monto					
14	30 Name and address of person who co Melissa Brassell, MD Ass	mpleted cause of death (Item 23a sistant Medical Examiner		Baltimore, MD 21	201						
State Registra		32. Registrar's Signature	A Salah								

28855

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*			eraļ tor	
	land	M.	9	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryl Department of Health and Mental Hygiene. Important: If teme 23 e or 28a-f sho amprofant: If tem 27 is marked other than "natural", or iteme 23a or 28a-f sho amp injury or other traumatic event, the Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- State Registrar Certificate of Death Reg. No.														
an	1. Decedent's Name (First, Middle, Las Estelle Rosemary								2. Date of De Month Septem	D	8	Year 2006	3. Time of Death 9:00 A M		
eal ier	4a. Facility Name (If not institution, give 6817 Hillmead Ro		ər)		4b. City, 1		Location hesd		Береси		c. County	of Death			
	5. Social Security Number 322-30-0503 1	ex 7 □ M 2☑ F	Age (In yrs. ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da August 2	Yea	[917	9. Birth Cou Mich	place (State or Foreign ntry) nigan		
	Usual Residence of Decedent		1												
ctor	Maryland Montgon	nery	Tuc. City	, Town or Lo	etheso	la							10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
ai Dire	10e. Street and Number 6817 Hillmead Ro	ad			10f. Zip 21	Code 0817				10g. 0		what Cou ted S	<sup>ntry?</sup> States		
Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 21 If Yes, Give Year or Date:	s? ⊠No	ŀ	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexical Specify:		ecify Yes or No Rican, etc.)	-	Bla	ce - Americk, White,			
ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4d	or 5+)	16a. Deced (Give life. L Profe				it of worki	ng	Ge	orge	town	ness/Industry own University School		
BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,						
To B	Harry Rubin								Levine						
	19a. Informant's Name/Relationship (19a. Rame)		nter		-				20M, N				Code) York 10024		
	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Removal from Sta	20b. Pla	ace of Dispo metery, cren	sition (Nam natory or ot	ne of ther place	e)	Sept	ember	20c.	Location	- City or To	own, State		
	4 Donation 5 Other (Specify)  Montgomery Crematorium Inc. 9, 2006  21. Signature of Funerat Service Licensee  M01433  Montgomery Crematorium Inc. 9, 2006  Bethesda, Maryland  22. Name and Address of Facility Robert A. Pumphrey Funeral Ho Bethesda—Chevy Chase Inc. 7557 Wisconsin Avenu  Bethesda, Maryland 20814														
	23a. Part1. Enter the disease, or com	plications that caus	sed the death.							rrest,			Approximate		
	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ine.	Disea									Interval Between Onset and Death		
	Sequentially list conditions	Due to (or	as a consequ	ence of):											
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):											
/Medical Examiner	that initiated events resulting in death) Last	Due to (or	as a consequ	ence of):											
dic		d													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal at time of de	death 3□	]Ectopic pre ] Other (spe							te of deliv	ery Day Year		
y Ph	Part II. Other significant conditions	ontributing to death	but not resu	Iting in the ur	nderlying ca	ause give	n in Part I		23e. Did t	obacco	use con	tribute to t	he cause of death?		
ed p									10	Yes	2 🔼 No	3 🗌 Prol	bably 4 Unknown		
Completed by Physician									24a. Was autop perfo 1 Yes			death?	opsy findings available ompletion of cause of 2 No		
Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)					
은	1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpa		R/Outpatien			4 🗆 140		me 5 🔀 Resid				fy)		
ation:	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	1	njury Day Year)	28b. Time of Injury	M 28	Bc. Injury Work 1 🗆 Y	at ? ∕es 2 □		28d. Describe I	now in	ury occur	red			
Certific	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At hor etc. (Specify,	ne, tarm, str	eet, factory,	, office			28f. Location (: City or Tox	Street a	and Numb ite)	oer or Run	al Route Number,		
Medical Certification:	29a. Certifier 1 🔀 Certifying Ph (Check only one) 2 Medical Exem	ysicien: To the be niner: On the basis and manner	s of examinati	vledge, death on and/or inv	occurred a	at the tim in my op	e, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause( date a	s) and mand place,	anner as s and due t	stated. o the cause(s)		
×	29b. Signature and title of certifier	Silan.	5		29c.		number 41 D.	C.			_		Day, Year) 8, 2006		
	30. Name and address of person who Richard D. Schub					Ave	nue,	NW #	348, W	ash	ingto	on, D	.c. 20016		

State Registrar

Drivin 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SEP 1 2 2006

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200628856 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Smith E. Louis 3:46 A September 6, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt. 217 7801 Peninsula Expressway Baltimore Co. Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X□M 2□F Jan. 24,1920 86 Maryland Director 212-16-2753 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or Itams 23a or 28a-f show vant, the Medical Examinar must be notified at 1 ☐ Yes 2X No Dundalk Directo Maryland Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Apt. 217 7801 Peninsula Expressway United States 21222 filed within 72 hours after death Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No 5 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygier
Important: If Item 27 is marked other it,
any injury or other traumatic avant, tha Construction Supervisor 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leathia Whitlock Joseph Smith 21222 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Apt. 217 Dundalk, MD 7801 Peninsula Expressway Mrs. Fern Smith (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Jesus Cem. 9/9/2006 Dundalk, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Insee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Maryland 21222 7922 Wise Ave. Dundalk, wood 23a. Part 1. Enfer the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Cancer Una mos - 4 /Medical Due to ( a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (List of it july) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attending Physicism: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. P After this certificate has been signed by the funeral director, page 2 should be deteched 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital t 🔁 Cartifying Physician: To the best of my knowledge death occurred at the time date and place and due to the dause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0063083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X Douth St reene 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 2006 THE START 1 Registrar

		•	For State Registrar	State of Ma	aryland / De	epart C <i>ertil</i>	ment of He ficate of D	ealth a D <mark>eath</mark>	and Ment	al Hygie	ne 2006	28857			
	Physici		1. Decedent's Name (First, Middle, Last)							ate of Death onth	Day Year	3. Time of Death			
	/Medic		Anna Lee Schmidt						Ser	ot.	2006	6:30 P			
)	Examin Funeral Director	er	4a. Facility Name (If not institution, give s.  Gilchrist  5. Social Security Number  214-14-3577  6. Sex		e (In yrs. last birtho	day) I	Towson f Under 1 Year fonths Days		24 Hrs. 8. Da Min. (M	ate of Birth fonth, Day, Y	Baltimore 9. Bin 6ar) 1920 N				
	و م		Usual Residence of Decedent		10c. City, Town of	ne L cont	ion					10d, fnside City Limits			
	ehov	7	MD Baltime	0.40								1 ☐ Yes 2 ☐ No			
	28a-f	Director	10e. Street and Number	Ji e	Coc		/sville 10f. Zip Code			10g	. Citizen of What Co				
	3a or	Ō	4 Harlow Ct.				2103	0			US	Α			
036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural; or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinating the notified at once.	by Funeral		2. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S.		s Decedent of His es, specify Cuban Yes 2 XNo	spanic Orig n, Mexican		es or No- , etc.)	14. Race - Ame Black, Whit	rican Indian,			
9	72 hou	Completed	15. Decedent's Educ	ation	16a. D	eceden Give kin	t's Usual Occupat	tion	t of working	16	b. Kind of Business	/Industry			
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)		d of work done du NOT use retired)		t or working		vil Servi				
2	tygier her th	S	12 17. Father's Name (First, Middle, Last)	n/a	T e	est	Examine		er's Name (Firs		ommission	<u> </u>			
Maryland 21215-0036	d be f antal h red of	o Be	John Leo Mueller,	Sr											
2	should nd Me mark mark	To	19a. Informant's Name/Relationship (Typ		19b. N	Mailing A	Address (Street ar		<u>atherin</u> ar or Rural Rou		ity or Town, State, a	Zip Code)			
ž	alth al		Tracy Alcarese/da	aughter	50	5 M	orris Av	/e.,	Luther	ville,	MD 21093				
Z.	of Hear of Hear of tram		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	mount from State			on (Name of ory or other place		Date		c. Location - City or				
Ĕ	Page ment ant: II		4 Donation 5 Other (Specify)	amovar nom State	Metro (	Crer	natory	ļ	9/8/06	Ca	tonsville,	MD			
Baltimore,	permit. Depart import eny inj			igle		Le 10	ame and Address mmon Fu W. Pado	unera onia	al Home Rd., T	e of D imoniu	ulaney Va ım, MD 2	lley, Inc. 1093			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused e cause on each lin	10.	t enter t	he <i>m</i> ode of dying	, such as	cardiac or resp	oratory arrest	,	Approximate Interval Between Onset and Death			
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
	Examiner			Due to (or as	a consequence of	):									
	A	Jer	Sequentially list conditions, in any, reading to immediate		a consequence of	).		-							
4	ficate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
Ö,	e exe ien ar urial-t	I Ex	resulting in death) Last	Due to (or as	a consequence of	):									
68760,	ficate be executed pphysicien and is the burial-transit	edical	d												
P.O. Box 6	The law requires that the death certifi ste has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√3 No 9 □ Unknowh	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf death		etopic pregnancy ther (specify)				23d. Date of de Month	fivery Day Year			
	that the		Part II. Other significant conditions con	tributing to death b	ut not resulting in t	he unde	orlying cause give	n in Part I.	. 2	3e. Did toba	cco use contribute to	the cause of death?			
rds	quires n sigr uld be	ed by								1 🗌 Yes	2 100 No 3 □ P	robably 4 Unknown			
Division of Vital Records,	e SEC	Completed		<u> </u>						4a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of			
/ita	Physicien: r this certifica ral director,	Be	25. Was case referred to medical examiner?	osnital:			7 -	r.	of Death (Che	20.5					
of	Physical this call dir	To T	1 Yes 2 No	ospital: 1 ☐ Inpatie 28a. Date of Inju	ont 2 ☐ ER/Outp		3 DOA Other	4 LI NU			e 6 Other (Spe	city) Mospice			
no	ding h. h. After funer	tion	1 Matural 5 ☐ Pending	(Month, Da)		ury	28c. Injury Work' M 1 TY	? ′es 2 🔲 1		763C1106 110W	infairy occurred				
Division	of or Attending after death.  Director: After din by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fni building, et	ury - At home, farn c. (Specify)	n, street			28f. L	ocation (Stre City or Town,	et and Number or Ri State)	ural Route Number,			
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier Certifying Phys		examination and/										
	To th within To th comp	Me	29b. Signature and title of certifier	0			29c. License				. Date signed (Mont				
)			* Anom	en,	•		D23	8303	>	7	& tenbu	12006			
	0		30. Name and address of person who co	mpleted cause of d	leath (ftem 23a) (T 660/ N	ype, Pri	ni)	SF	BARM	me o	no ura	7206			
5	Sta Regist		31. Date filed (Month, Day, Year)		ar's Signature	An	who !								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 20			Hygiene Reg. No. 2006 28858	
Physic /Med		1. Decedent's Name (First, Middle, Last)  George Leroy Sohn, Sr.	2. Date or Montb Septemb	
Exam		4a. Facility Name (If not institution, give street and number)  17820 01d Frederick Road	4b. City, Town, or Location of Death  Mount Airy	4c. County of Death  Howard
Funera Directo		5. Social Security Number  214-01-7865  Usual Residence of Decedent  6. Sex 1 XM 2 F 7. Age (In yrs. last birthday 91 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month August 2	, Day, Year) Country)
Maryland -1 show	for	10a. State 10b. County 10c. City, Town or U	Location	10d. Inside City Limits 1 ☐ Yes 2 No
or 28a	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ING 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "naturel", or Itams 23e or 28e-f show event, the Marical Everill set is as the marified at	by Funeral Director	1207 Mountain Road  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Wyes 2 No If Tes, Give Year or Dates: WWII	21085  Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 Yes 2 No Specify:	Inited States of America r No- 14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036  ad within 72 hours aft giene or then "naturel", or t, the Mudical Eneral	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Cotlege (1-4or 5+)  12  O	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) fanager	16b. Kind of Business/Industry  General Index  Manufacturing Company
Maryland 2121 d 2 should be filed within the and Mental Hygiene. 27 is marked other then traumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)  Charles Franklin Sohn Sr	18. Mother's Name (First, Mic Grace Murp	·
Maryla 12 should h and Men 7 is marka		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route Nu	
Baltimore, Maryls permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic		20a. Method of Disposition 20b. Place of Disposition cemetery, crit	ematory or other place)	20c. Location - City or Town, State
Balti permit. Departm Importa eny inju				yers Funeral Directors, I 11stown, Maryland 21133
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the law requires that the law requires the law requires that the law requires the law requires the law requires that the law requires that the law requires the law re	dical Examiner	Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on each line.  Interval Between Onset and Death O		
	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□ Cther (specify)	23d. Date of delivery Month Day Year
cords, P. Cords, P. W. requires that the been signed by should be detact	by	A CONTINUE OF THE SIGNAL CONTINUE OF THE CONTI		Did tobacco use contribute to the cause of death?
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Vivision of or Attending Physiter death. Director: After this in by the funeral di	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 100 Hospital: 1 Inpatient 2 ER/Outpatie	of 28c. Injury at Work?  M 1 Yes 2 No 28f. Locatic	
Division  To the Hospitel or Attent within 24 hours after death  To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  10a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one)  10a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
To the within To the comp	Me	29b. Signature and title of certifier  Mouvalures A	29c. License number  DO 8096	29d. Date signed (Month, Day, Year)  SIFFITEM PBR 8, 2006
	tate	30. Name and address of person who completed cause of death (Item 23a) (Type Andrew Nowakowski MD, 125 N. Main  31. Date filed (Month, Day, Year)  32. Registrar's Signature	s.Print) Street, Bel Air, Maryla	and 21014
Regis		SFP 1 2 2006	Goaslis	

State of Maryland / Department of Health and Mental Hygiene 2006 28860 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Scaggs Grace September 8, 2006 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Fairhaven Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 15, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2XF Yrs. Director 214-14-9165 85 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or Itame 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Carroll Sykesville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ā 7200 Third Ave. #A306 21784 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Briscoe Brawner Grace Pierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H.I. Rex Scaggs/Son 404 Rock Fleet Road # 303 Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulaney Valley Memorial Gardens September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. 4 □ Donation 5 □ Other (Specify) 11, 2006 Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cirrhosis MA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hep-1.6. Examiner MA w #0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and is the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2010 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 Tes 2 No 2 Accident Director 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Role J. Man, 32PP2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) riness Canton Dr. d 11055 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** September 8, William R. Sheldon, Jr. 2006 8:40 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 2909 Rayshire Road 5. Social Security Number 6. Sex Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth Apr. 11, 1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F Yrs Maryland Director 216-24-2643 73 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No MD N/A Baltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 Rayshire Road 21230 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Air Conditioning Sears Roebuck Co. permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if item 27 is marked othe any injury or other traumatic event, 9064. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William R. Sheldon, Sr. Mary Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Paulette Sheldon - Wife 2909 Rayshire Road, Baltimore, MD 21230 Baltimore, 20b. Place of Disposition (Name of Westernate Andream Prother place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State ☑Bonation 5 ☐ Other (Specify) 9-9-2006 Crematory Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. signature of Funeral Service Licens 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, complications that caused the shock, or heart failure. Just only one cause on each line. Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and stransit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Xyes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ZNo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . COLE 900 CATON AVE BALTIMORS MD ST AGNES 32. segistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM 1, 26 per PHYS. C859 9/12/06 WS
State of Maryland Department of Health and Mental Hygiene 2 0 0 6

Amend item#1, per 10, 8859, 9/13/06 TT Cortificate of Death

1 - For Stata Registrar Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) CHARLES R. SKELLY Skellev September Physician 0:15 AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Mary land Medical Center Baltimore , Mary N/A 8. Date of Birth (Month, Day, Year) 50 lana University If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-52-2064 1 → M 2 □ F Yrs. 56 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Pres 2 □ No Funeral Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 U.S.A. 134 West Ostend Street filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊮Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Restoration Specialist Bricklayers Union other it of Health and Mental Hyg If Item 27 ie marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Philip Philip D. Skellev Jones Hazel ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 West Ostend Street Baltimore Maryland 21230 Bonnie Skelley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. 9/6/06 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCully Polyniak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical ţ, use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy atten for u Day 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2.No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 2 No 1 Tyes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 1 No 1. Inpatient 2 ☐ ER/Outpatient 3□ DOA After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatura D Street 31. Date filed (Month, Day, Year) State 2006 SEP 12 Registrar

6-06712	Please Typ	oe or Print in	Black Indelible Ink				
Ronald T. Stevens	State of Maryland /	Department of	of Health and Mental H	ygiene			
	1- For State Registrar	Certificate c	of Death	Reg. I	No 201	16 288	36:
Physician/	Decedent's Name (First, Middle,Last)			Date of Death     Month     Date	v Year	3 Time of Death	/ ψ `
Medical Examiner	Ronald T. Stevens			September 7		1022 hrs	
gen way	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	1	4c County of Death	h	

**Funeral** Director

or 28a-f show 23a or 28a-f show notified at ouce. with the Maryland or items the Medical Examiner "natural".

rector

Funeral Yes Divorced Yes Give Year Yes 2 X No specify à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene
Important: If item 27 is marked other than Injury or other transmatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor 17. Father's Name (First, Middle, Last) Edward Stevens, Sr. Regina Doody 19a. Informant's Name/Relationship (Type, Print ) Edward Stevens, Jr./Brother 20b Place of Disposition (Name of cemetery, 20a Method of Disposition Date West Arundel Crematory Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify Signature of Funeral Service Licensee Physician /Medical failure List only one cause on each line Narcotic (heroin) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED item#23a.27.28a-f.perME.o859.9/15/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c If ves, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Completed 25 Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician: Be Hospital 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28c Injury at Work? 28b. Time of Injury 27 Manner of Death 28a Date of Injury (Month, Day, Year Certification: Natural Yes 2 X No 5 Pending Fnd 9/7/2006 Fnd 9:20 am unk 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be thin 24 hours at the Funeral E (Specify) house Homicide 29a Certifier 1 Medical (Check only one) 0 and manner stated 29b Signature and title of certifier O.C.M.E 30 Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

St. Agnes Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6 Sex 7 Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. Foreign Country) MD Min Months Davs Hours 47 April 2, 1959 214-82-3615 1 Z M 2 Usual Residence of Decedent 10c City, Town or Location 10d Inside City Limits 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10a Citizen of What Country 1820 Spence Street 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 XMarried 1 Never Married 2 X No. Specify: White 16b. Kind of Business/Industry Home Improvement 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 Burgess Ave Parkville MD 21214 20c. Location - City or Town, State 9-15-2006 Odenton, Maryland 22 Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Lansdowne MD 21227 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death 23d Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No. 1 🗸 Yes 2 No Nursing Home 5 Residence 6 🗸 Other Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 248 Clyde Avenue Halethrope, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) September 8, 2006

ORIGINAL

		•	For State Registrar		State of Mar		Departmer <i>Certificat</i>			Mental H	ygien Reg. N	711111	5 28	864
	Dhosiai		1. Decedent's Name (First, Mic	ddle, Las	t)		\			2. Date of D		ay Year	3. Time o	
	Physicia /Medic		CHARLE	7 6	7500065	. Sc!	732dH	ER			rwe	5610 you		2 M.
•	Examin		4a. Facility Name (If not institut	tion, give			4b. City,	Town, or L	ocation of Deat	h	4	c. County of Dea	0.	
H			5. Social Security Number	6. Se	5/12/2 ex 7. Age (	In yrs. last bin	thday) If Unde	1 Year	If Under 24 Hrs	8. Date of B	lirth	100	thplace (State	or Foreian
	Funeral Director		217-14-9017		M 2 F		Yrs. Months	Days	Hours Min.	(Month, I	Day, Yea	131 18	CULA (	
	p ,		Usual Residence of Decedent			Oc. City, Town	ar Leasting				1	1	10d Inside (	Site I limite
	shov	7	10a. State 10b. Cour	niy		F-9							10d. Inside 0	ity Limits
	the M	ecto	10e. Street and Number	7/11	10:15	76	10f. Zig	Code			10a C	itizen of What C		
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	me 2	Funeral Director	11. Marital Status	3 ( 02)	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece	dent of His	panic Origin? (S , Mexican, Puer	pecify Yes or N	10-	14. Race - Ame		
2	s i and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Mudical Exami, art must be multified at	y Fu	1 Never Married 3 M		t Yes 2 No		1 Tes, spe		Specify:	io nican, etc.)		Black, Whi	e, etc.	
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<u>a</u>	should bents and Ments amarked	70 E	CHARLES	1	SCHLEET	TIR			LORA	B.T	6.17	DR		
0	2 shd and is m		19a. Informant's Name/Relation	onship (7	ype, Print)	19b.	Mailing Address	(Street ar	nd Number or Ri	ural Route Num	ber, City	or Town, State,	Zip Code)	31334
ב ט	1 and Health Jum 27 Ther tr		20a. Method of Disposition	- 5	12131H2	20h Place of	Disposition (Na.	17.37	ROW	0 - 1917 Date	331	Location - City or	Town State	RAPANO
5	Pages nent of It int: If ite		Burial 2 Crematio		Removal from State	cemeter	y, crematery or	other place,	1525	, Hi	200.	ile Cos	Man and	\ ^
	교육육급 .		4 Donation 5 Other  21. Signature of Funeral Servi	-		2 ENSKI	22. Name a	d Address	of Facility	00p	11th	(KN1779	1 18153	LANU
0	permit. Depart import any inj		A Const	NO			SVAN	400	EDBY C	000 8	13:00	on 5/12	84/200	34
			23a. Part1. Enter the disease, shock, or heart failure. L	or comp	olications that caused the	e death. Do r	not enter the mod	le of dying,	such as cardia	c or respiratory	arrest,	1	Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition		Camal	carro	NS OF	Parl	einson	diven	10		Onset and	Death
	/Medical Examiner		resulting in death)		Due to (or as a c			-					1	
	LAGIIIIII	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b. Due to (or as a c	consequence (	of):							
	nsit	mlne	Cause (Disease of Injury	≺	250 10 (0) 25 4 1	, or i o o o	J. 7.							
5	exection and ital-tra	Examiner	that initiated events resulting in death) Last		Due to (or as a c	consequence	of):					·		
5	flicate be executed g physicien and ts the burial-transit	edical			d									
5	ertifica ling ph e as t		IF FEMALE:											
	eath certif ettending for use a	ian/	23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tin	Fetal death	3 □Ectopic p 5 □ Other (s					23d. Date of de Month	livery Day	Year
j	w requires that the death cer been signed by the ettendin should be detached for use	Physician/M	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown	ne or death	3 □ Other (s)	ecity)						
<u>.</u>	s that ned b e deta	by Pr	Part II. Other significant cond	litions co	ontributing to death but	not resulting in	the underlying	ause giver	n in Part I.	23e. Dio	tobacco	use contribute to	the cause of	death?
3	en sig									1 [	Yes	2 No 3 □ P	robably 4	Unknown
2	law re as be 2 sho	piet								24a. We	s an	24b. Were a	utopsy findings completion of	available
	The ate h	Completed								per 1 ☐ Yes	formed?	death? lo 1 ☐ Yes	2 □ No	5 <b>45</b> 55 5.
	icien: entific ector,	Be	25. Was case referred to medi examiner?	-	Hamital.				26. Place of De					
5	Physic this c	- To	1 ☐ Yes 2 No  27. Manner of Death		Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Ou			4   Nursing F	dome 5 ☐ Re		6 Other (Spe	cithnosp	iù
5	ding h. After funer	tion	1 ∰Natural 5 🗆 Pen	iding estigation	(Month, Day Y		njury	28c. Injury : Work? 1 □ Y	es 2∐No	28d. Describe	a now in	ury occurred		
2	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐ Cou	-	28e. Place of Injury	- At home, fa	rm, street, factor					and Number or R	ural Route Nur	nber,
5	s afte el Dire ed in t	Certification:	4  Homicide		building, etc.	(Ѕресіту)				City or T	own, Sta	te)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	(Check only 2 Medic	lying Ph	ysician: To the best of e	xamination an	, death occurred d/or investigation	at the time	e, date and place	e, and due to thurred at the time	e cause( e, date a	s) and manner a	s stated.	s)
	the thin 2 the the the the the the the the the the	Med	29b. Signature and the of cert		and manner state	d.		c. License				ate signed (Mon		
	F S		X	ar	lus				200			fember		20
ĺ	0'		30. Name and address of pers	on who	completed cause of dea	th (Item 23a)	Type, Print)					, , , , , ,		
-			30. Name and address of pers  Anon Off  31. Date filed (Month Day Ye	w	com 6600	ew. C	harles	57	BAM	ore and	7 21	zay		
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	Registr	ar	OF L	N -	NAME OF THE PARTY	1	Man State St							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 6:30 PMM September 9, 2006 Michael E Spurrier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8634 Delegge Rd. Baltimore Rosedale If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/09/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months **₩** M 2□ F 58 MD 214-50-7400 Director Usual Residence of Decedent 10c. City, Town or Location 10d, fnside City Limits 10a. State 10b. County 28a-f ehow r then "natural", or items 23a or 28a-f ehov tre Medical Examinar must be tuctified at 1 Yes 2 No MD Rosedale Baltimore Direct 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21237 8634 Delegge Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Caucasian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Public Schools al Hygiene. Coflege (1-4or 5+) Elementary/Secondary (0-12) Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be f Mental I Virginia Davis Elmer Spurrier Pages 1 and 2 should Department of Heeth and Milmportant: If item 27 is mariany injury or other traumations. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8634 Delegge Rd. Rosedale, MD 21237 Mrs. Levita Spurrier/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Beltsville, Maryland 9-12-06 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licenses 8717 Green Pastures Drive Baltimore, Maryland Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma of orophonynx **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to for as a consecuence of Examiner physicien end s the burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) မှ 28a. Date of Injury (Month, Day Year) ierel Director: After th 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D40850 September 11, 2006 - Oth MO 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 9103 Franklin Square Dr. BAIDMire MD 21237 OTTAVIANO MD VONNE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 12

		4	For State Registrar	State of Maryl		partment of receiving the contract of the cont			Reg. No.			
		-	Decedent's Name (First, Middle, La	st) - F				2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic	_		JAME.	\$ 5			SEPTE	MBER	9,2006	01.45 PM	<b>V</b>
	Examin		4a. Facility Name (If not institution, give	1,000	V N+		r Location of Death Baltim	ore	4c. Co	unty of Death	A	
			FUTURECARE  5. Social Security Number 6.5		yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bird (Month, Da	th		lace (State or Foreig	gn
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	land ow	-	10a. State 10b. County	100	. City, Town o	r Location				1	0d. Inside City Limit	
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	h with the	Funeral Director	10e. Street and Number 264 South Loudon Ave	nue		10f. Zip Code	21229		10g. Citizer	of What Cour	-	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Examination and in a marked other traumatic event, If a Medical Examination and its contilied at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify:		
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occup live kind of work done fe. DO NOT use retired	ation during most of worki	ing	16b. Kind	of Business/In	dustry	
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and	ould be f Mental I arked or atic eva	To Be		P. Scott, Sr.				Mary	Foster	Scott		
ary	S should be filed within and Mental Hygiene. Is marked other than aumatic evant, If a M	-	19a. Informant's Name/Relationship	(Type, Print)	19b. N	failing Address (Street					Code)	
	and 2 palth a n 27 ls ar tran		Shirley Jackson			264 South Lou						
Baltimore,	e		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 i  1 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	cemetery,	isposition (Name of crematory or other planets)  Vit. Zion Cemete	сө)	09/14/06		tion - City or To ndsdown,		
≡	permit. Pa Departmen Important: any injury once.		21. Sign Ture of Funeral Service Lice			22. Name and Addre	ss of Facility	10	D 4			
ä	Depar Impo any ir	5 58	- Ull	e. Esel		1300 E	rothers Funer utaw Place Ba	ai Service, Itimore, Mo	21217			
н			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the y one cause on each line.	death. Do no	enter the mode of dyli	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in dealth)	Due to (or as a co	nsequence of	:						
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	ertifica ding pl		IF FEMALE:	23c. If yes, outcome of pr	regnancy				23	d. Date of deliv	erv	
P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at time	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) □	у		23	Month	Day Year	
٩.	that hed by a deta	y Ph	Part II. Other significent conditions				ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?	
rds	quire an sig	ed b	END STAGE	RENAL	Di	SEASE		1 🗆	Yes 2	No 3 ☐ Prol	pably 4 Unknov	wn
Division of Vital Records,	e law has b je 2 sl	mplet						24a. Was auto perf		24b. Were auto prior to co death? 1  Yes	psy findings availab impletion of cause o	ole of
<u>a</u>		a	25. Was case referred to medical				26. Place of Deat			1 163	2010	
Z	9 V 17	ToB	examiner? 1 ☐ Yes 2 X No	Hospital: 1   Inpatient	2 ER/Outp	atient 3 DOA	her: 4 X Nursing Ho	ome 5 ☐ Res	idence 6 [	□Other (Speci	(y)	
0		<u> </u>	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tir Inj	ury Wo	rk?	28d. Describe	how injury	occurred		
Sioi	Attending r death.  actor: After by the fune	catio	2 Accident investigate 3 Suicide 6 Could not	ha		-	]Yes 2 □No	39f Location	(Stroot and	Number or Pur	al Route Number,	_
Divi	al or Att	Certification:	4 Homicide determine	28e. Place of Injury - building, etc. (S	At nome, tarr pecify)	n, street, factory, office		City or To	wn, State)	Namber of Har	ar riodie reamber,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of meminer: On the basis of examiner stated.	amination and	death occurred at the to or investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) a , date and p	nd manner as s lace, and due t	sfated. o the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	41 (		2	se number		1	signed (Month,		
	*		Movaso	inthalcur	nor.	CMD D	42510		SEP"	1. 4, 2	2006	
	H		30. Name and address of person who	o completed cause of death A KUMA  32 Registrar's	(Item 23a) (7	ype, Print) 6. N. Roc	LING ROI	40 # 1	08,	MD2	1228	
		ate	31. Date filed (Month, Day, Year)	32, Registrar's	Signature	100000						
	Regist	rar	SEP124	UUU AM								

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sept 1, **Physician** 2006 8:40 A M Katherine Shunk /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Largo Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept 22, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday): **Funeral** Year Days Hours 1 □ M 2 □ F 1913 Mary1and Director 214 48 1848 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location works. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show ampinjury or other traumatic event, the Madical Examinat must be notified at once. Maryland Prince George Largo 1 ☐ Yes 2 XXVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 20815 United States 8700 Jones Mill Road 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21√21√No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maryland School Board School Systems 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2406 Porchester Road, Upper Marlboro, MD 20774 Mary Lynn McManamen (Friend) Sept 7gate2006 | 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Upper Marlboro MD St. Mary's Assumption Church Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multi system Immediate Cause (Final Inouth Physician disease or condition resulting in death) /Medical Examiner UVOF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Division of Vital Records, P.O. Box 68760, Cly To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and if or use as the burial-transit Malw Vieron Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Airin the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s rmeg. 2 X XIo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) eral Director: After th 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Upper Maulbour 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 CHAMPA LOUX 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sittle State of th Registrar

			- For State Registrar		State	of Maryla	and / Dep	artmer rtifical	nt of H	lealth a	and M		Heg. No.	200	6	2886
	Physicia /Medic		1. Decedent's Name Richard			tz						2. Date of De Month Septem	Day	11 20°	06	3. Time of Death 3:24a
	Examin	er	4a. Facility Name (h Carroll	Hospital				West	mins					County of D Carrol	1	
	Funeral Director		5. Social Security N 215-34-60	84	Sex M 2□ F		rs. last birthday, Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Feb 21	th 1 <sup>19</sup> 1 <sup>7</sup> 93.	5 M	Birthpl Bount	ace (State or Foreigi ry)
Maryland	f show	tor	Usual Residence of 10a. State MD	10b. County Carrol	1	10c.	City, Town or L	ocation dbine	)						10	d. Inside City Limits
h with the	at be notil	ai Director	10e. Street and Nur 532 Hood		Road			f	797				_	izen of What SA	Count	ry?
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. important; or items 23a or 28a-f show important: If item 27 is marked other than "natural; or items 23a or 28a-f show sry injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2∏Marneo 4 □Divorced	Armed 1 □ Ye	ecedent Ever ir Forces? s 2 ☐ No Give r Dates:	- 1	Was Dece If Yes, spe 1 \( \text{Yes} \)				ecify Yes or No Rican, etc.)	)-	14. Race - A Black, W Specify: W	/hite, e	itc.
<b>215-0</b> 0 hin 72 ho	an "natur Medical	Completed	(Spec	15. Decedent's ify only highest o	grade complete	ed) e (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u	ork done i ise retired	during mos d)				ind of Busine		•
Baltimore, Maryland 21215-0036	ontal Hygiene ced other that c event, the	To Be Corr	12 17. Father's Name ( George F	(First, Middle, La	st)		owner	of	power	18. Moth	er's Nam	nt co. • <i>(First, Middle</i> : Pearl	, Maiden		1 pn	ent
Maryl Maryl	alth and Me 27 is mark or traumati	ř	19a. Informant's Na Shirlee S		(Type, Print)		532	Hoods	s Mil	.1 Rd		al Route Numb				Code)
more, Pages 1 a	nent of He int: if item iry or oth			position Cremation 3 5 Other (Spe			o. Place of Disponentery, cre . View				9–15-	-06		ocation - City iottsv		
Balti permit.	Departra importa sny inju		21. Signature of Fu	neral Service Lic	1	オ	2 F	2. Name a	nd Addre	ss of Facili	<sup>ty</sup> Ha:	ight Fu ville,	nera Md 2	1 Home 1784	& &	Chape1
Ex	nysicien and Medical the private in	I Examiner	23a. Part1. Enter it shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list condition and the cause. Enter Under Cause (Disease or that initiated events resulting in death) if	nt failure. List on (Final n Inditions, Inmediate orlying injury	a	to (or as a const	sequence of):	Chn		ey such as	Lm	3	irrest,			Approximate Interval Between Onserend Death
Division of Vital Records, P.O. Box 68760,	ned by the attending physicien detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2€ 9 ☐ Unknown	months?	1⊡Liv 4⊡Pre	outcome of pre e birth 2 ☐ F egnant at time o	etal death 3	⊒Ectopic p ⊒ Other (s		,				23d. Date of Month		ry Day Year
ds, P.	s been signed by	þ	Part II. Other signif	ficant conditions	s contributing to	death but not	resulting in the i	underlying	cause giv	en in Part I	1.		tobacco i Yes 2			e cause of death?
Recor	certificete hes beer rector, page 2 shou	Completed										24a. Was auto perfe 1 Yes		deati	ኅ'/	osy findings available appletion of cause of
Yician:	is certifica director,	To Be (	25. Was case referexaminer?	-	Hospital:	☐ Inpatient 2	ER/Outpatie	nt 3⊡ D	OA Oth	er.		h (Check only				
Division of Vital Records, P.O. Box 6 or Attending Physician: The law requires that the death certific	within 24 hours after death.  To the Funeral Director; After this certificete he completely filled in by the funeral director, page	Certification; 1	27. Manner of Deat  1. Natural  2 Accident  3 Suicide  4 Homicide	h 5 Pending investigat 6 Could no determin	t be 28e. Pla	te of Injury fonth, Day Year ace of Injury - A ilding, etc. (Sp	At home, farm, si	м		yat k? Yes 2⊡		28d. Describe 28f. Location City or To	Street an	nd Number o	r Rurai	Route Number,
he Hospital	within 24 hours.  To the Funeral completely filled	edical	29a. Certifier (Check only one)	12 Certifying 2  Medical Ex	aminer: On the	the best of my e basis of exam anner stated.	knowledge, dea nination and/or i	rvestigatio	n, in my o	pinion, dea	nd place, ath occur	and due to the red at the time,	date and	d place, and	due to	the cause(s)
D 10T	with To t	×	29b. Signature and	title of certifier	>					e number	81			te signed (M		
	5		30. Name and addr	ress of person wh			item 23a) (Type	Print)	Way	, Su	ite 1	14 Et	ders	borrs n	10	21784
	Sta		31. Date filed (Mon	oth, Day, Year)	2006 32	2. <b>Registrar'</b> s Si	gnature	The same								

			1 - For State Registrar	State of Ma	aryland				ealth a			Reg. No.	20	06	281	869
	Physici	an	1. Decedent's Name (First, Middle, La	*							Date of De.     Month	ath Day	`	'ear	3. Time of D	
	/Media	cal	JAMES <sub>EDWIN</sub>		LOR		41. 03.	T	Location of	( Death	Septeml		County of		9:00	a <sup>M</sup>
1	Examir	ner	4a. Facility Name (If not institution, giv 9014 Rhode Islan		#810	`			e Par							
	Funeral		5. Social Security Number 6. S	ex 7. Ag		ast birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da				orge's ace (State or I	Foreign
	Director		215-62-4899	MM 2□F	42	Yrs.	Months	Days	Hours	Min.	2-6-1	964	1	lary.	Land	
	and *		Usual Residence of Decedent  10a, State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City	Limits
	Maryl f eho	ō	Maryland Prince	George's	,	llege									1∭Yes 2	
	r 28a	rect	10e. Street and Number	George S	00	TTERE		Code				10g. Citi	zen of Wh	at Count	ry?	
	23a o	Funeral Director	9014 Rhode Islan	d Avenue.	#810			2074	0			II.	S.A.			
	eme .	Iner	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)		4. Race -	America White, e		
36	s afte	by Fu	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	No		1 🗆 Yes		Specify:			1	Specify:			
21215-0036	72 hours after death with the Maryland naturel', or iteme 23a or 28e-f ehow disal Evaninar must be redilled at	edt	15. Decedent's E			16a. Dece	dent's Usu	al Occupa	tion				nd of Busi			
215	hin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	ide completed)  College (1-4or 5	i+)	(Give life.	kind of wo	ork done d ise retired)	uring most	t of workii	ng				,	
2	ed wit	Completed	12		.,	<u>Driv</u>	er								nsport	:
Maryland	be file	Be	17. Father's Name (First, Middle, Last						18. Mothe	r's Name	(First, Middle,	Maiden	Surname)			
3	hould d Mer marks matic	2	Kenneth Edwin Sa  19a. Informant's Name/Relationship (	<b>4</b>		10h Mailie	o Addros	c (Stroot a			n Adams		Tour C	ato Zio	Codal	
Na	od 2 s Ith an 27 is 1		Irene M. Sampson								ngs, Ma				,	
5	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturet", or iteme 23a or 28a-f show any injury or other traumatic event, It a Madical Examinar must be notified at ODGs.		20a. Method of Disposition		20b. Pi	ace of Dispo	sition (Na	me of			ate Ings, ric		cation - C			
Ë	Page net o int: if		1 🕅 Burial 2 📮 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			t Linco				9/13	/2006	Brei	ntwoo	d. M	íarvlar	nd
Baltimore,	permit. Departminimports Imports eny inju		21. Signature of Funeral Service Lice	See A					s of Facility	y Gase	ch's Fu	nera	1 Hor	ne,	P.A.	
<u> </u>	8958		+allet	11/00			739	Balti	more	Ave	., Hyat	tsvi	11e,			
	Physician /Medical Examiner		23a, Part h Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease of condition resulting in death)	a. <b>Diabete</b> Due to (or as	ne. s Typa a consequ	oe II,	Unco	ntro		cardiac o	r respiratory ar	rest,			Approximate Interval Betwe Onset and De	
J	sate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronar  Due to (or as  c	a consequ	ence of):	ıseas	se								
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9	ifficate g phy as the	edic		u.												
P.O. Box	the death certificate be executed the attending physicien and ached for use as the burial-transitiached	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s					2	3d. Date (		y Day Yea	ear
	law requires that the de as been signed by the a 2 should be detached f	Ď	Part II. Other significant conditions of Gross non compli		ut not resu	Iting in the u	nderlying	cause give	n in Part I.			obacco u: /es 2]	_		e cause of dea ably 4 []Unl	
al Records,	The ate h page	Completed									24a. Was autop perfo 1 🗆 Yes	sy rmed?	dea	ith?	sy findings av apletion of cau 2 No	vailable use of
of Vital	Physician: Th this certificate ral director, pag	B	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o					
oţ	ਦ ਦੁਣ	. To	1 ☐ Yes 2 📉 No  27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatien 28b. Time of		7	4 🗆 140		ne 5 🕅 Resid					
on	Attending Phir death. ector: After thi	ţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		/ Year)	Injury	м	28c. injury Work 1 □ Y	? ′es 2.⊟1			,,				
Division	To the Hospital or Attence within 24 hours efter death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At hor c. (Specify	me, farm, str	eet, factor	y, office		2	28f. Location (S City or Tox	Street and vn. State)	d Number	or Rural	Route Numbe	er,
	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier 1 Cartifying Ph (Check only one) 2 Madical Exam	ysician: To the best on niner: On the basis of and manner sta	examinati	viedge, death ion and/or inv	occurred vestigation	at the time	e, date and inion, deat	d place, a th occurre	and due to the dead at the time,	cause(s) date and	and mann place, and	er as sta	ted. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	1			29	c. License		. /		29d. Date	signed (	Month, D	ay, Year)	
			PELLINATIV	W				)/	140	4		Jop	torul	Al/	1200	06
	1			completed cause of d						11					/	
	C.	10	Charles Franklin 31. Date filed (Month, Day, Year)	MD 1112			shire	Aver	nue,	#408	, Silve	r Sp	ring	MD	20904	
	Sta Registr		or bate the (month, buy, real)	2006	orginal	At 1	Jonas !	1								

DHMH 17 Rev 1/2001

06-06638 Lawrence C. Sharp

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physicia cal Examir		edistrar	ficate of Death	Reg. No.	200
		Decedent's Name (First, Middle, Last) Lawrence Christopher Sharp		Month Day Year September 4, 2006	2033 hrs
		4a. Facility Name (if not institution, give street and number)  Montgomery General Hospital	4b. City, Town, or Location of Death Olney	Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 217 – 88 – 8022 1 X M 2 F	Months Days Hours Min	Foreign	lace (State or try)Germany
Maryland 28a-f show any 1 at once.	٦	Usual Residence of Decedent  10a. State	own or Location		0d. Inside City Limits Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 17736 Overwood Dr.	10f. Zip Code 20832	10g. Citizen of What Country USA	n
or items 23	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Ď	Elementary/Secondary (0-12) College (1-4 or 5+)	1 Yes 2 X No specify:  6a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use ret		
filed within al Hygiene. ed other than	Be Completed	17. Father's Name (First, Middle, Last) Lawrence Royal Sharp	Disabled  18.Mother's Name Sally Sal	e (First, Middle, Maiden Surname) £ah1	
d 2 should be Ith and Ments n 27 is mark numatic even	ToB	19a Informant's Name/Relationship (Type, Print) Lawrence R. Sharp/father	19b. Mailing Address (Street and Number or 17736 Overwood Dr. 0	lney, MD 20832	
Pages I and Iment of Heal tant: If iten		1 Burial 2 X Cremation 3 Removal from State cre 4 Donation 5 Other Specify: Che	ace of Disposition (Name of cemetery, ematory or other place)  sapeake Crematory 9-	Date 20c. Location - City or To Beltsville,	
injury		21. Signature of Funeral Service Licensee Moc 38 Z  22. Signature of Funeral Service Licensee Moc 38 Z  23. Part I. Errier the diseale, or complications that caused the death. D	Rapp Funeral & Cr	Silver Spring, MD20 emation Svc.933 Gist or respiratory arrest, shock, or heart	910 Ave.
Medical kaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Seizure Disorder  Due to (or as a consequence of):			Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
icate be executed physician and the burial - transit		d.  X LINPENDED AMENDED			
cate be physici he buri	n/Medical	iF FEMALE: 3b. Was decedent pregnant in the past 12 months?  3b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	23d. Date of delivery	
	/sicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		Year
the death certif by the attending ched for use as	by Physician	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not rest	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	cause of death?
aw requires that the death certif has been signed by the attending 2 should be detached for use as	by	1 Yes 2 No 9 Unknown 9 Unknown	ulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probab  24a Was an autopsy performed? 24b. Were autop prior to comdeath?	e cause of death?  bly 4  Unknown  by findings available opletion of cause of
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ding Physician: The law requires that the death certif After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by	Part II. Other significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributions contributions contributions contributions contributions contributions contributions contributions contributions contributions contributions contributions contributions contributions con	26. Place of Death (Check R/Outpatient 3 DOA Other   Nursi 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No ne, farm, street, factory, office building, etc.  29c. License number O.C.M.E.	24a Was an autopsy performed? 1 Yes 2 No 3 Probab  24b. Were autop prior to comdeath? 1 Yes 2 No 1 Yes  only one)  1 Residence 6 Other:  28d. Describe how injury occurred  28f. Location (Street and Number or Rural or Town, State)  d due to the cause(s) and manner as started at the time date and place, and due to the cause (s) Date signed (Month September 5, 2006)	e cause of death?  Ply 4 Unknown  Day findings available appletion of cause of  2 No  Route Number, City  Lause(s)  Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2006

			State of Maryland / Department of Health and Mental Hygiene 2006 2887   Certificate of Death Reg. No.
	Physicia /Medic	ian	1. Decedent's Name (First, Middle, Last)  El Viva Speak  2. Date of Deeth Month Type 20 2006 7 mm
)	Examine		4a Facility Name (If not institution, give street and number)  4b. City, Town, or Locetion of Death  4c. County of Death
	Funeral Director		5. Social Security Number  3. Social Security Number  4. Sex  1 Months  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Yrs.  1 Under 1 Year  1 Under 24 Hrs.  Months  Days  Hours  Min.  8. Date of Birth  Month, Day, Year  Country)  9. Birthplace (State or Foreign  Country)  M D
Within 72 hours after death with the Marylend	th end Mentel Hygiene. 7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, the Medical Examinal must be notified at	Funeral Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   10d. Inside City Limits   10d. Street and Number   10f. Zip Code   10g. Citizen of What Country?   2858
be filed	ntel Hygiene. ed other than "natural", event, the Medical Exp.	œ l	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)
, - H	ment of Heal ant: if Item 2 ury or other	To	George Washington Carver Annie Norman  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5 Usan Lang  1321 Home Stead St. Balto. MD 21018  20a. Method of Disposition  1 Burial 2 A Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Green mount Cemetery 9-8-06 Baltimore MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part, Error of Funeral 2431 E. Oliver St  23a. Part, Error of Funeral 2431 E. Oliver St  23a. Part only one cause on each fine reserving property arrest, Paper Returned Property Ret
icate be exacuted	ysician yselcian end properties of the private state of the private stat	edical	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
The law requires that the death certif	signed by the ettending p d be detached for use es	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death 2  1   Yes 2   No 3   Probably Unknown
RECORDS,	been	Completed by	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of deeth?
VILCA stctsn:	s certificate director, pag		25. Was case referred to medical examiner?  Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: A Mursing Home   5   Residence   6   Other (Specify)
or Attending	Iter death. Irector: After ti n by the funera	Certification: T	27. Manner of Death   Natural   S   Pending
To the Hospital or within 24 hours as	the Funeral npletely filler	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.  Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month/ Day, Year)
, T	_		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	State Registra	) ate	31. Date filed (Month, Day, Year)  SEP 1 2 2006  32 Registrar's Signature  SEP 1 2 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Dhysis:		Registrar		COL	lilicate of	Death		Re	eg No	UUb	200
Physicia al Exami	an/	1. Decedent's Name (First, Mic Shawn Slyke			-			Date of Deal     Month     September	Day Yea	1 1	ne of Location 04 hrs
		4a. Facility Name (if not institute Prince George County)	_	ımber)	4	b. City, Town, or Lo Cheverly	cation of Death		4c County of Prince G		
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	8 Date of 8in	th (MM/DD/YYYY)		(State or
Director		207-54-5575	1 M 2 X F	38	Yrs.	Months Days	Hours Min.	03/04	/1968	Foreign Country	ennsylva
		Usual Residence of Decedent						1 03/04	71900	<u> </u>	ennsyrva
y any		10a. State 10b. Count	,		Town or Location	on					nside City Limits
Maryland 28a-f show a d at once.	ত		ce George	La	ndover						Yes 2 No
Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene in: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner	Director	10e. Street and Number 7304 Barlow Ro	oad			10f. Zip Code 2078	85	11	0g. Citizen of Wh USA	at Country?	
h with t ems 23a t be not	Funeral	11 Marital Status 1 Never Married 2	1 4 4 5	cedent Ever in U.S		Decedent of Hispa			- 14. Race White	- American Inc	dian, 8 lack,
ter death ", or ite er must			1 Yes	2 X No	i	Yes 2X No s			Specify:	B1a	ack
2 hours afte "natural",   Examiner	d by	15. Decedent's Education (Sp	Lor Dates.		16a, Decedent	's Usual Occupation	(Give kind of we		16b Kind of Bus	siness/Industry	,
72 bo	leted	Elementary/Secondary (0-12	College (*			st of working life. D					_
ted within 72 Hygiene other than the Medical	omp	12			Photogr	apher/Mak			Magic		c Co.
Hygi Hygi d oth	ပ၂	17 Father's Name (First, Middl				18.			Maiden Surname)		
d be i lental narke event	o Be	John Sewell  19a. Informant's Name/Relation			I 10h Mailing	Address (Street a	Gloria		the City of Town	01-1-7-0	. 1.2
2 shoun th and N 27 is n imatic	۲	Gloria Jones/				sapeake S					
permit Pages I and 2 should be fited with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition  1 X Burial 2 Cremation	on 3 Removal fr		lace of Disposit rematory or other	tion (Name of cemet er place)	tery,	Date	20c. Location -	City or Town,	State
		4 Donation 5 Other	Specify:	For		oln Cemet		16/2006	Brentw	ood, M	D
permit Departn Imports injury 6		21. Signature of Fur eral Service	te Licensee		22 Na Fo1	ame and Address of Lincoln Bladen	Facility n_ Funera	al Home			
	-	23a. Part I. Enter the disease,	or complications that of	quead the death							0722 oximate Interval
ysician /ledical		failure. List only one caus	se on each line								veen Onset and Death
aminer		Immediate Cause (Final diseas or condition resulting in death)		12 ASSOC12 consequence of		acquired a	mmune defi	iciency s	syndrome		Deall
		Sequentially list conditions,	b.	oonboquence on	/-						
	ner	if any, leading to immediate cause. Enter Underlying Caus		consequence of	):						
	Examiner	(Disease or injury that initiated events resulting in death) Las	C	consequence of	):					_	
= I											
nd nd rans		events resulting in death, Eds	d								
e executer cian and rial - trans			d AMENDED	item#23a.	27 nerME	o860 10/6	/06 TT				
cate be executer physician and the burial - trans		X UNPENDED	AMENDED 23c If yes,	outcome of pregn		,g860, 10/6			23d Date of	delivery	
ifficate be ng physici as the buri	n/Medical	X UNPENDED	AMENDED  23c If yes, 1 Live b	outcome of pregn oirth	2 Feta	al death 3	/06 TT  Ectopic pregnan	ncy	23d Date of o	delivery Day	Year
33 33	sician/Medical	W UNPENDED  IF FEMALE: 23b. Was decedent pregnant in	AMENDED  23c If yes, 1 Live to 4 Pregr	outcome of pregn orth nant at time of dea	2 Feta			псу			Year
33 33	Physician/Medical	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c If yes, 1 Live by 4 Pregr	outcome of pregn oirth nant at time of dea own	2 Feta	al death 3 er (Specify)	Ectopic pregnar			Day	
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To the topping on Authoring Physician: The law requires that the death within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  U  Part II. Other significant concessions of the concession of the conc	al Hospital: 1 28a Date (Month lud not be termined)  Physician: To the best aminer: On the basis and manner sfier  Assistant Med	outcome of pregnorth nant at time of deal own o death but not re Inpatient 2  of Injury Day, Year) e of Injury - At ho st of my knowledg of examination an tated.	ER/Outpatient 28b. Time of In me, farm, street le, death occurre ad/or investigation 23a) er 111 Pe	26.Place of 3 DOA Otl jury 28c. Injury at, factory, office builded at the time, date on, in my opinion, do 29c. License n	Death (Check or her 4 Nursing at Work? 2 No ding, etc. 2 and place, and ceath occurred at umber E.	23e Did to 1 Yes 24a. Was a autop perfor 1 Yes 3 Home 5 28d. Location (\$ or Town, \$ due to the caus the time, date in the caus the time, date in the caus the time, date in the caus the time, date in the caus the time, date in the caus the time, date in the caus the time, date in the caus the time, date in the cause the caus	Month  bbacco use contrib  2 No 3  an 24b W sy pr med? 2 No 1  Residence 6  now injury occurre  Street and Numbe tate)  e(s) and manner and place, and du  29d Date signe	Day  Day  Dute to the cau  Probably  Vere autopsy fire to complete eath?  Yes  Other  or or Rural Roules started.  Lee to the cause of (Month, Day)	se of death?  Unknown  Indings available on of cause of  No  No  te Number, City

		For Amend item 2:  = State   Registrar		Cei	tificate	of Dea	ath		Reg. No.	000	28873
Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
/Medica	al -		Schaeffer					08	Day 3	2006	4:07 AM
Examine		4a. Facility Name (If not institution, give s Fran Klin Squar	e Huspital		R	sedo	ition of Death		Bo	ty of Death Uhin	ore
Funeral Director		5. Social Security Number 6. Sex 123-09-2088 6. Sex	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Months		urs Min.	8. Date of Birt. (Month, Day Jan23,	1920	9. Birthp Cour	lace (State or Foreign try)
. >		Usual Residence of Decedent	100	Since Transport						-	
on show	. !	MD Baltim		City, Town or Lo	dle R	iver					0d. Inside City Limits 1 ☐ Yes 2 🔀 No
important: if team the marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ā	10e. Street and Number 526 Crisfield	Road		10f. Zip (	ode 220			10g. Citizen of	What Cour	itry?
r must	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	nt of Hispan	ic Origin? (Sp	ecify Yes or No-	14. Ra	ace - Americ	
Machin	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □XYes 2 □ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2		ecify:			ity: Wh:	
lica i	ed -	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual	Occupation	most of work	rina	16b. Kind of	Business/Ind	dustry
the Mad	Completed by	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	DO NOT use	retired)	Offic	•		rtmer fense	
vent	Be C	17. Father's Name (First, Middle, Last)						e (First, Middle,	Maiden Surna		
vatic .	و ا	William Schaef						s Flea			
rtraum		19a. Informant's Name/Relationship (Type Darlyn Warwick						a <i>l R</i> oute Num <i>b</i> e l Balti			Code)
or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b	Place of Dispo cemetery, crer Bayvier	sition (Name	of er place)	- 1	Date	20c. Location		
inlury	-	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			. Name and			10-			
Suc Suc		P. Terr	y Conne	$I \cap I$			3 (	00 Mace L Home			
cian		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eal ons that caused the de	!			Pneum		rest,		Approximate Interval Between Onset and Death
edical miner		ſ	Due to (or as a cons	f(f)	GI	Bleed					
- 1	luer	Eaquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ( r as a cons	equence of):							
rial-tran	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):							`
the burial-transit	dicai	d									
70 00	in/Me	230. was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pred	manov			23d. D	ate of delive	ry
detached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of		Other (spec				M	lonth	Day Year
ğ j	Dy Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cau	se given in l	Part I.				e cause of death?
plnode	eted							1 ☐ Y			ably 4 □Unknown
N I	Completed							autop perfor		prior to cor death?	osy findings available inpletion of cause of 20 No
0	ge	25. Was case referred to medical examiner?		1		T .	Place of Deat	h (Check only or			
al dire	<u> </u>	1 ☐ Yes 2 ☑ No H	+	ER/Outpatien			☐ Nursing Ho	ome 5 Resid			')
the tuner	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М 260	. Injury at Work? 1 ∐ Yes	2 □No	28d. Describe h	ow injury occu	irrea	
in ka ui pi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory,	office		28f. Location (S City or Tow		ber or Rura	Route Number,
ely fill	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred at restigation, in	the time, da my opinion	te and place, , death occur	and due to the cred at the time, c	ause(s) and mate and place	nanner as st , and due to	ated. the cause(s)
complet	Σ	29b. Signature and title of certifier	1/			icense num			29d. Date sign		
		· Jack	10 MD		D	5588	55		8/31/	06	
		3 Name and address of person who co	me ed cause of death (It	em 23a) (Type.	Print)						
2	4	I Dr. TACK KM	9000 IV	anklin	Salla	vo T	VIVA.	Balt	MAN	21	237

DHMH 17 Rev 1/2001

			1 - Stata Amend #1	State of Mar Oe <b>per FH G</b>	yland / De 359 9/12	partment of F	lealth and l Death	Mental Hygie	ene 1. No. 2006	28871
	Physic		1. Decedent's Name (First, Middle, La	Smith	•			2. Date of Death Month	Day Year 10 200L	3. Time of Death
1	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)			r Location of Deat		4c. County of Death	,
	Funeral		1-1100	OSPICE 7. Age (	In yrs. last birthda	y) If Under 1 Year		8. Date of Birth	Baltin 9. Birth	Plone.
	Director		72 00.004	1□M 2 <b>X</b> F	54 Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) Cou	ntry) VA
	yland		Usual Residence of Decedent  10a. State 10b. County	1 1	Oc. City, Town or					10d. Inside City Limits
	he Mar 28e-f sl	ector	MD N	A	Balt	imore				1)ZYes 2□No
	h with t	al Dir	10e. Street and Number Alar	neda Enga		10f. Zip Code	21239	10g	g. Citizen of What Cou USA	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28e-f show other treumatic event, the Maxical Exprinter must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 Selvo If Yes, Give Year or Dates:	er in U.S.	3. Was Decedent of H If Yes, specify Cubin	dispanic Origin? (S an, Mexican, Puert Specity:	pecity Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: B	etc.
21215-0036	"natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retired	during most of wor	rking	ib. Kind of Business/In Burtington	
212	filed within Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Con	puter D	perator	(	0	ctory
and	I be filed ntal Hygi ed other event, II	Be	17. Father's Name (First, Middle, Last Reuben Wats			1	18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)	
Maryland	2 should to and Ment is marked	스	Keuden Wats  19a. Informant's Name/Relationship (		19b. Ma	iling Address (Street	and Number or Ru	iral Route Number, C	City or Town, State, Zip	Code)
	s 1 and 2 of Health a item 27 is other tre		Barry Smith /1	tusband	le21	57 The A	lameda		Tore MD	21239
Baltimore,	permit. Pages 1 Department of H importent: if ite any injury or ot once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State (y)	cemetery, ci	position (Name of rematory or other place 10/10/ Parl	(co) L 19/14		c. Location - City or To	
Ba	Depar impor any ir		21. Signature of Funeral Service Lips	hen	7	22. Name and Addre	Greene E	uneral ser	VIO 2121	2
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the	e death. Do not e	enter the mode of dyir				Approximate Interval Between
Ag .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ust co	encer				Onset and Death
	Examiner		<b>(</b>	Due to (or as a c	onsequence of):					
	ed selt	iner	Sequentially list conditions.  Tany laading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a o	onsequence of):					
ó	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
8760	cate be ohysicie the bu	dicai		d						
Box 6	death certific: e attending pl ed for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of delive	erv
P.O. B		Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		Dectopic pregnancy			Month	Day Year
	es the Igned be de	þ	Part II. Other significant conditions of	contributing to death but r	ot resulting in the	underlying cause giv	en in Part I.		cco use contribute to the	
cord	w requir been s should	eted						1 Tes		pably 4 Unknown
Vital Records,	The law ete has b	Completed						24a. Was an autopsy performed	prior to condeath?	ppsy findings available mpletion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th Check only one		
of	g Phys er this eral dii	n; To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	2 ER/Outpati	of 28c. Injur	y at	ome 5 Residence 28d. Describe how	ther (Specification)	n hospice
Division of	Attending r death. ector: After by the fune	catio	1 Sqatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n		M 1 🗆	Yes 2 □ No			
DΖ	el or At eletter i Direct d in by	Certification;	4 Homicide determined		- At home, farm, s Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	To the Hospitel or Attending within 24 hours effect death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  Certifying Physics (Check only one)	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To the within 2	Me	29b. Signature and title of certifier			29c. Licenso			Date signed (Month,	
0			30. Name and address of person who	completed cause of door	(Itam 23a) (Turn	DOD Print)	51926	5	ept 10,	2006
8			Helen M. Gardo	N MD 657	5 W, C	Shades S	- Balt	more my	ept 10, :	
	Sta Registr	100	31. Date filed (Month, Day, Year)	D	Signature	all s				
DHI	MH 17 Rev 1/2	-	SEP 1 2 200	O AND SEA	and the same					

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryl			of Health			iene	nne	28875
	Physici /Medi		Decedent's Name (First, Middle, La HERMAN	ast)			SODY		2. Date of Dea Month Septembe	th Day	Year	3. Time of Death 4:47 AM M
7	Examir		4a. Facility Name (If not institution, gi Greater Baltimore		ter		own, or Location	ol Death			nty of Death	
	Funeral Director			Sex 7. Age (In y	rs. last birthday, Yrs.	If Under 1		Min.	8. Date of Birth 11/18/1		9. Birthp Cour	place (State or Foreign ntry) MD
	death with the Maryland me 23a or 28a-f ehow f must be notified at	Olrector	MD         BALTIM           10e. Street and Number	IORE BA	City, Town or L	10f. Zip C			1		of What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☐ No ntry?
920	after or Its	by Funeral Director	725 MT. WILSON L  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ANL API. #401  12. Was Decedent Ever in Armed Forces?  1  Yes 2 No Will #8s, Give Year or Dates:	n U.S. 13.				ecify Yes or No- Rican, etc.)	14. P	J.S.A. Race - Americ Black, White, city: WH]	etc.
121215-0036	led within 72 hours ygiene. her then "naturel", it, Ine Madical Exi	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	DO NOT use	done during mo retired)	SENTA	ATIVE	FURNI		dustry
Maryland	nould be fill I Mental H narked ott natic even	To Be	17. Father's Name (First, Middle, Las SAMUEL			SODY	AN	NA	(First, Middle, I		,	YOUSEM
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumatic event, II a Mappee.	1	19a. Informant's Name/Relationship HARRIETTE SODY / 20a. Method of Disposition	WIFE	725 M	T. WIL	SON LAN	E APT	-	BALTI	vn, State, Zip MORE, n - City or To	MD 21208
Baltimore,	permit. Pages Department of Important: If I any injury or ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Fineral Signature	<sub>fy)</sub> BA	cemetery, create	HEBRE	W CONG		0/2006 LEVINS	REIST	ERSTO	WN, MD
B	permi Depa Impo any ii		23a. Part1. Enter the disease, or con	nplications that caused the de	8	900 RE	ISTERST	OWN R	0AD - P	IKESVI		MD 21208 Approximate
1	Physician /Medical Examiner		shock, of heart lailure. List only Immediate Gause (Final disease or condition resulting in death) Sequentially list ounditions	a. Septicon  Due to for as a cons  DRIVING	retenti	en					-	Intérval Between Onset and Death 2 days 3 days 3 weeks
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list on clitics if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	allux							3 web
P.O. Box 68	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic preg Other (spec		= 20			Date of delive	ory Day Year
	w requires that been signed is should be det	ed by P	Part II. Other significant conditions	contributing to death but not a	resulting in the u	nderlying cau	se given in Part	ł.	23e. Did tob			e cause of death? ably 4 DUnknown
Division of Vital Records,	: The law ricate has be	Completed by							24a. Was ar autops perform 1 Yes 2	v	prior to cor death?	psy findings available inpletion of cause of
r Vit	Physician: The this certificate har director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA	04		(Check only one		ther (Specifi	,)
sion o	ng Ph Iter th Ineral	Certification: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Surcide 6 Could not be			M 280	injury at Work? 1 ☐ Yes 2 ☐	2	8d. Describe ho			,
Divi	To the Hospitei or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4  Homicide determined		ecify)				181. Location (Str. City or Town	, State)		
	the Hos nin 24 ho the Fun npletely	Medical	one) 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or in	vestigation, in	n my opinion, de	ath occurre	d at the time, da	ite and place	e, and due to	the cause(s)
	J. W. T.		29b. Signature and title of certifier	Medical	Ductor	L V	icense number	_			ned (Month, l ひしし	
1	2		30. Name and address of person who	5 6701 N	land CV	Print)	Stret. C	BMC	Rusa	n, M	D 7	1204
100	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Rose St.	R					

Amend #8 per Fil G859 12 06 JH Ensure All Copies Are Legible.

			1 - For State Registrar	-	State of M	larylan	d / Depa	artmen rtificat	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No	20	06	28	8876
	Physic /Medi		1. Decedent's Name MARION	e (First, Middle, Las	t)			CHATZ				2. Date of De Month Septemi	ath Da	٧	Year		of Death
	Examinum Funeral Director		4a. Facility Name (III  Greater  5. Social Security No. 081–20–0	Baltimore	Medical	Cente	er last birthday) Yrs.	4b. City,  TOW:  If Under  Months	son 1 Year	If Under Hours		8. Date of Bir (Month Da 09/13/	Ва	County  1 time	ore 9. Birth		te or Foreign
	yland ow		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation								10d. Inside	City Limits
	Ba-f et	ector	MD		TIMORE		OWING										es 2 No
	h with ti	ai Dire	10e. Street and Nun 12018 RI	DGE VALLE	Y DRIVE			10f. Zip		117			10g. Cit	izen of V		intry?	
980	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, Ira Medical Examinar must be notified at 2008.	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 🏋 Widowed	ed 2∏ Married 4 ∏ Divorced	12. Was Decedent Armed Forces 1  Yes 2 W Il Yes, Give X Year or Dates:	? No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe	ectfy Yes or No Rican, etc.)	)-	14. Race Blac	k, White	can Indian , etc. HITE	,
21215-0036	I within 72 ho liene. r then "natur Itse Madical	Completed	(Speci Elementary/Secor 12	15. Decedent's Ed ify only highest grad ndary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	life.	dent's Usua kind of wor DO NOT us MAKER	rk done d se retired)	uring mos	t of workii	ng		ind of Bu			
	ibe filed ntal Hygi ed other event, ii	To Be C	17. Father's Name (	(First, Middle, Last)				EPHS			er's Name	(First, Middle		Sumam	ю)		
Maryland	2 should and Men Is marke sumatic	P	19a. Informant's Na	me/Relationship (7			19b. Mailir	ng Address		nd Numbe	er or Rura	l Route Numb		or Town, i	State, Zi		
	s 1 and f Health Item 27 other tr		20a. Method of Disp	MALMUD /	NIECE	20b. P	lace of Dispo	sition (Nan	ne of	1		E - OW				MD 2	
Baltimore,	Pages ment of tent: If It		4 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specify	)		metery, crer THEL	MEMOR	IAL	(		/2006				WN, N	
Bal	permit Depara Import eny in		21. Signature of Fur	neral Service Licens	Z	$\rightarrow$						CEVIN					
	Physician /Medical Examiner		Immediate Cause ( disease or condition resulting in death)	Final	ne cause on each i	ine. Mati s a consequ	remic			, such as	cardiac o	r respiratory a	rrest,			Approxir Interval I Onset ai	Between nd Death
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		Due to (or as  Due to (or as	t fa	uence of):								1	2da	46
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro						23d. Date Mon		ery Day	Year
	w requires that been signed b should be deta	Ď	Part II. Other signifi	cant conditions co	ntributing to death t	out not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u Yes 2				of death?
of Vital Records,	:: The law requicate has been ; page 2 should	Completed	//.									24a. Was autop perfo 1  Yes		l pi	rior to co	ppsy findin impletion o	gs available f cause ol
Vit	ysician: The is certificate hi director, page	To Be	25. Was case referr examiner?  1 Yes 2 X	1	Hospital:	ent 2 □ 1	ER/Outpatien	t 3 DO	A Othe			Check only o	-	6 □Othe	ar (Snaci	54)	
Division o	tending Physicath.  tor: After this the funeral dis	27. Manner of Death  1 Natural  5 Pending (Month, Day Year)  28b. Time of Injury Mork?  1 Yes 2 No									now injur	y occurre	∍d				
Div	7 5 5 6	Certif	289. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify)  281. Location (Street and Number or Rural Ro									al Route N	umber,				
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai (	29a. Certifier (Check only one)	1 CCertifying Phy 2 Medical Exam	sician: To the best iner: On the basis of and manner st	of examinat	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	o, date and nion, deat	d place, a th occurre	nd due to the	cause(s) date and	and mar I place, a	nner as s	tated. o the caus	e(s)
	within To th	Me	29b. Signature and	title ol certifier	0 0 0				License				29d. Dat	e signed	(Month,	Day, Year	)
	7		30. Name and addre	met	Whale				Di	186	39			7/8	120	106	
l			Aime	e Whea	ton mp	6701	N. C.	harles	s St	Bau	et n	no ala	204	1			
s	Sta Registr		31. Date liled (Monti	n, Day, Year) P 1 2 2008	32. Registr	rar's Signat	ure	10									

06-06746 Wendy Thompson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certification Certifi	ficate of Death	Reg No.	16 2881
Physicia Medical Exami	an/	1 Decedent's Name (First, Middle,Last)	THOMPSON	2. Date of Death Month Day Year September 8, 2006	3. Time of Death 0711 hrs
		Facility Name (if not institution, give street and number)     Harbor Hospital Center	4b. City, Town, or Location of Death Baltimore	4c. County of Death	1
Funeral Director		5 Social Security Number 214-94-8616 6. Sex 7. Age (in yrs. last	birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min		thplace (State or gn enry 1and
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a State	own or Location Baltimore		10d Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 302A E. Patapsco Ave	enue 10f. Zip Code 21225	10g Citizen of What Cou	ntry?
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		ican Indian, 8lack, White
24 3 3	Completed by	15. Decedent's Education (Specify only highest grade completed) 1  Elementary/Secondary (0-12) College (1-4 or 5+)	6a Decedent's Usual Occupation (Give kind of during most of working life DO NOT use ret	work done 16b. Kind of 8usiness/	,
15-0036 Ted within 72 Hygiene d other than ",		10 0 17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene n 27 is marked other than umatic event, the Medica	To Be	Joseph Earl Ball  19a Informant's Name/Relationship (Type, Print) JoAnn Bonita Ball (Mother)	JoAnn  19b Mailing Address (Street and Number or 3295 Chaneyville Rd.	Rural Route Number, City or Town, State	
re, s   an f Heal f iten	ij	4 Vousial 3 Commetica 3 Removed from Chata	and the state of t	Date 20c. Location - City or Elkridge,	Maryland
Baltimo pernit Page Department o Important: injnry or oth		21 Signature of uneral Service Licensee Kevin E Ecke:	r 22 Name and Address of Facility McCully-Polyniak F 237 E. PAtapsco Av	Tuneral Home, P.A. ve., Balto., Md. 2	1225-1856
Physician /Medical rxaminer	i i	23a. Fart I Enter the disease, or complications that caused the death. D failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (Methador Due to (or as a consequence of)	o not enter the mode of dying, such as cardiac one and Oxycodone) intoxicat:	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
<b>&gt;</b>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ecuted and - transit	al Examiner	events resulting in death) Last Due to (or as a consequence of):			
760, cate be exemply sician the burial -	/Medical	X UNPENDED AMENDED item#23a,2  IF FEMALE 23c If yes, outcome of pregna	27,28a-f,perME,g859,9/28/06	TT 23d. Date of deliver	/
Box 68760, s death certificate be the attending physici d for use as the buri	Physician/	23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 4 ☐ Pregnant at time of death 1 ☐ Live birth 9 ☐ Pregnant at time of death	2 Fetal death 3 Ectopic pregni		Day Year
P.O. E res that the c signed by the be detached	Ş	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e Did tobacco use contribute to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed				topsy findings available completion of cause of
Vital Re ssician: The his certificate director, pag	Be	25. Was case referred to medical examiner?  1  Ves 2  No  Hospital 1  Inpatient 2  E	26 Place of Death (Check R/Outpatient 3 DOA Other Nursi	only one)  ng Home 5 Residence 6 Other	
n of V ding Phys After thi funeral d	n 5	27. Manner of Death 28a Date of Injury (Month. Day Year)	8b. Time of Injury 28c Injury at Work?	28d Describe how injury occurred	-
Sion Attendi r death ector:	catio	2 Accident investigation 290 Place of Injury At hom	Fnd 6:45 am 1 Yes 2 X No ne, farm, street, factory, office building, etc.	unk 28f. Location (Street and Number or Ru	iral Pouta Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Suicide 6 A Could not be 4 Homicide determined (Specify) Hous	e II	Baltimore, MD A Fast	Patapsco Ave.
To the H within 24 To the F complete	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and and manner stated			
- > - 3	Ž	29b. Signature and title of certifier	29c License number O.C.M.E.	29d Date signed (Mo September 8, 20	
		30. Name and address of person who completed cause of death (Item 2:	3a)		
	ate	Pamela Southall, MD Assistant Medical Examine  31. Date filed (Month, Day, Year) 32. Referrar's Signature		21201	
Regis		31. Date filed (Month, Day, Year) 32. Residerar's Signature SEP 1 2 2006	it from		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/1, 688, per FH/PHYS, 689, 9/20/06, WS
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	artmer <i>tifica</i> i	t of H	ealth and Death	Mental F	lygien Reg. No	200	6	28878	3
*	Physici /Medic		1. Decedent's Name (First, Middle, La Kim Tracy	OK YON KII	I TRACY	7				2. Date of Month Sept	Da	iy Y 006	'ear	3. Time of Death 5:00 A M	
7	Examin Funeral Director	_	4a. Facility Name (If not institution, given 3617 Lumar Dries 5. Social Security Number 6. Social 976 9243	ve	o (In yrs. last t	oirthday) Yrs.	For		hington ff Under 24 Hrs Hours Min	th  8. Date of	Birth	County of Princ	e	George's     State or Foreign	7
	B	ior	Usual Residence of Decedent  10a. State 10b. County	George's	10c. City, To			ingto	n					0d. Inside City Limits 1 ☐ Yes 2 \( \frac{1}{2} \) No	
	3a or 28a	Funeral Director	10e. Street and Number 3617 Lumar Driv	<i>r</i> e			10f. Zij	Code 207	'44			tizen of Wh			_
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 le marked other then "natural", or Iteme 23e or 28e-f ehow early fujury or other treumatic event, the Medical Examinar must be notified at QDGs.	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes, Give A Year or Dates:		1	Was Dece f Yes, spe	dent of Hi city Cubai	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or ito Rican, etc.)		14. Race -	Amend White,	an fndian,	_
21215-0036	within 72 hou ane. then "natura	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation		(Give life. L	kind of wo	se retired,	urina most of wo	orking		Gind of Busin		dustry	_
Maryland 2	ould be filed Mental Hygid arked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last UNKNOWN			FIO	uucc	10015	18. Mother's Na	me (First, Mid			•		
e, Mar	1 and 2 sho Health and sm 27 le m ther treum		19a. Informant's Name/Relationship ( William Tracy (Hu 20a. Method of Disposition		20b. Place	3617	Lum	ar Dr	ive, Fo		ingto		20	744	_
altimore,	mit. Pages pertment of to cortent: If Its Injury or or		1 Maurial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Services Lices	y)	ceme	te <i>ry</i> , cren .awn	ceme	other place tery	Sept 12	, 2006	Roo	ckvill	e,	Maryland 6633 Old	
ä	Der Der		23a. Part 1. Enter the disease, or com shock, or heart faifure. List only	b moiz	the death. D	A1	exan	dria	Ferry R	oad, C1	intor				
68760, 7	Physician /Medical Examiner sthe principle of the princip	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as	a consequence a consequence a consequence	e of):	Car	cip	ioma					Onset and Death	
P.O. Box 6	death certii e attending id for use a	Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yeo 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf dea		]Ectopic p ] Other (s <sub>i</sub>	regnancy oecify)			-	23d. Date of Month		ory Day Year	
	law requires thet the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	contributing to death b	ut not resulting	in the ur	ndertying	cause give	n in Part I.		id tobacco			ne cause of death? ably 4 Unknown	
al Reco	: The law recete has been page 2 sho	Completed								₽€	as an itopsy informed? s 2	prio	or to cou	psy findings available npletion of cause of 2  No	
Ž.	certifi rector	8													_
ō	Physra rahdi	. To	1 Yes 2 No  27. Manner of Death	1 ☐ Inpatie	nt 2 ☐ ER/0	Jutpatien . Time of		JA	4 Livursing	Home 5 A				v)	
Division of Vital Records,	or Attending Physician: efter death. Director: After this certifice I in by the funeral director, p	1 Matural   5 Pending investigation   2 Accident   3 Suicide   4 Homicide   6 Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street, factory)   28f. L											or Rura	I Route Number,	-
	To the Hospitel of within 24 hours el To the Funeral Completely filled in											s) and mann d place, and	er as s	ated. the cause(s)	
)	To the vithing To the the complex comp	M	29b. Signature and title of certifier  D Rooss  30. Name and address of person who	Jamondz	Sath (Itam 22)	) (Type		c. License D19				18 [0		Day, Year)	
	4		Rosario Fernanc					ve Su	ite 102	,					
45	Sta	te	31. Date fifed (Month, Day, Year)		ar's Signature	W .	Press								_

			1 - For State Registrar		ryland / Depa Ce	artment of H rtificate of I	lealth and M Death		-g	6 2887
	Physic /Medi		1. Decedent's Name (First, Middle, Las Theresa R.	Taylor				2. Date of Deat Sept.	8 <sup>Day</sup> 2006 <sup>Yee</sup>	3. Time of Death 3:58a M
	Exami		4a. Facility Name (If not institution, give Gilchrist Cent	er		Towso			4c. County of D	
	Funeral Director		5. Social Security Number 6. Security Number 11 Sec	7. Age	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth  Jana	931	Birthplace (State or Foreign Country)
	Maryland B-f ehow	tor	10a. State 10b. County MD Baltir	nore	10c. City, Town or Lo	ocation ldle Riv	er			10d. Inside City Limits 1 ☐ Yes 2 🚰 No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 107 Conestoga	Road		10f. Zip Code 21 220		10	0g. Citizen of What USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show styling or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: V	
Baltimore, Maryland 21215-0036	within 72 ho lene. 'then "natur he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation le com <i>pleted)</i> College (1-4or 5-	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Lemaker	ation during most of worki )	ng	Own ho	
land 2	uld be filed fental Hygi rked other iic event,	To Be Co	17. Father's Name (First, Middle, Last)  Victor Buczko	wski			18. Mother's Name	(First, Middle, N		
, Mary	and 2 shoulally and Milly and Milly and Milly and Milly 127 ie mailer traumailer traumailer		19a. Informant's Name/Relationship (TDAve Taylor /sc	•					City or Town, State	
imore	Pages 1 ament of He ant: if Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20b. Place of Dispo cemetery, cree Bayvie	esition (Name of matory or other place W Crema	tory 9/1		20c. Location - City Baltimo:	
Balt	Departi Departi Import eny inj		21. Signature of Funeral Service Licens	y Con		2. Name and Address Connelly		0 Mace 1 Home	Ave. E	Balto. MD ex 21221
7	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SINIC	e	er the mode of dying	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	consequence of):					
68760,	ifficate be executed g physicien and as the burial-transit	edicai Exe	resulting in death) Last	Due to (or as a	consequence of):					
O. Box	ath certi trending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ONo 9 □ Unknowh	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
<u> </u>	w requires that the der been signed by the a should be detached to	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause give	on in Part I.			to the cause of death?  Probably 4 Monknown
Il Records,		Completed					_	24a. Was an autopsy perform	prior t death	autopsy findings available o completion of cause of ?
Vital	nysician: Th nis certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Death			
Division of	ding Phys h. After this funeral di	atlon: To	1 Yes 2 No   27 Manner of Death  1 No Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28c. Injury Work	4   Nursing Hon	ne 5 Resider 28d. Describe hor		pecify) hospice
DIVIS		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	2	28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,		
	To the Hospitel or within 24 hours afte To the Funeral Director completely filled in I	edical	one)	sician: To the best of her: On the basis of and manner state	my knowledge, death examination and/or inved.	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	and due to the called at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	or with	Σ	29b. Signature and title of certifier	lus		29c. License	T8303	29	d. Date signed (Mo	nth, Day, Year)
	5		30. Name and Odress of person who co	5 m 6	601 N.Cl	Print) NVUS St	Baron	no me	21204	
3,4%	Sta Registr	1.00	31. Date filed (Month, Day, Year) — \$PP 1 2 2	32. Registra	's Signature	anoll s				

DHMH 17 Rev 1/2001

06-06806 Patrick Tocci

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1-For State Of Maryland / Depar Registrar	ificate of Death	_	g. No. 2006 2006
Physici ledical Exam	an/	1. Decedent's Name (First, Middle,Last) Patrick Tocci		2. Date of Deatl Month Septembe	Day Year
and a		4a Facility Name (if not institution, give street and number) Bayside Avenue	4b. City, Town, or Lo Rockhall		4c. County of Death Kent
Funeral Director		5. Social Security Number 188–38–9121 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year  Months Days  Yrs.		h (MM/DD/YYYY)  9. Birthplace (State or Foreign Country)  PA
Aaryland 28a-f show any 1 at once.	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  PA Carbon  10c. Street and Number	own or Location Palmerton  107. Zip Code	110	10d Inside City Limits 1 XYes 2 No
th the Mary 23a or 28a notified at	I Director	410 Kennetta Lane	18701		USA
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mural Hygiene 17 is marked other than "natural", or items 23a or 28a-f Sho ratic event, the Medical Examiner must be notified at once	ted by Funeral	11 Marital Status 1 Never Married 2 Married 2 Married 1 Never Married 2		n (Give kind of work done	14 Race - American Indian, 8 lack, White, etc.  White Specify:  16b. Kind of Business/Industry Steel
5-0036 iled within 72 Hygiene 1 other than '	Completed	12 3	Structural Steel D		
21215-003 uld be filed withi Mental Hygiene marked other tt	Be Co	17. Father's Name (First, Middle, Last) Patrick Tocci	. 18	Mother's Name (First, Middle, Marjorie Pha	
MD 2121 and 2 should be t lealth and Mental tem 27 is market traumatic event	욘	19a Informant's Name/Relationship (Type, Print) Patrick Tocci / Son		and Number or Rural Route Num  1 Road Lititz,	ber, City or Town, State, Zip Code) PA 17543
SE L of H of H		4 Duriel 2 Comption 2 V Removed from State CF	ace of Disposition (Name of ceme ematory or other place) Igh Valley Cremator	Sert. 13.	20c Location - City or Town, State Hellertown, PA
Baltimo permit. Page Department Important: injury or ot		21. Signature of Fune al Service Licensee	22 Name and Address o Charles L. 1501 Fast, F	f Facility Stevens Funeral Ho ort Ave Baltimore	me Inc.
Physician /Medical Examiner		23a. Part I. Enter the disease, or collocations that caused the death I failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Do not enter the mode of dying, su	uch as cardiac or respiratory arre	Sst, shock, or heart  Approximate Interval Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause			
uted Id	Examiner	(Disease or injury that initiated events resulting in death) Last d			
760, cate be executed physician and he burial - transi	edical	UNPENDED AMENDED			20d Data of delines
	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnate in the past 12 months?  1 Pregnant at time of dealing the pregnant at time of dealing in the past 12 months?	2 Fetal death 3	Ectopic pregnancy	23d Date of delivery  Month Day Year
ires that the d signed by the	by Phy	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause giv		bacco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
cords law requinas been	Completed			24a. Was a autop perfor	sy prior to completion of cause of med? death?
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 I		of Death (Check only one)	Residence 6 ✔ Other: Scene
ion of Virtending Physiceath  Or: After this the funeral dir	tion: To	27. Manner of Death  1 Natural 5 Pending  28a Cate of Injury (Month, Day Year) Sep 9, 2006	28b. Time of Injury 28c Injury		now injury occurred
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	1 3	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Bay	me, farm, street, factory, office bui	or Town, S	Street and Number or Rural Route Number, City tate) Chseapeake Bay, Rockhall, MD
To the Hose within 24 hd To the Fun completely		29a. Certifier 1 Certifying Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination an	e, death occurred at the time, dated and/or investigation, in my opinion, or	e and place, and due to the caus death occurred at the time, date	e(s) and manner as started and place, and due to the cause(s)
To To cor	Me	and manner stated  29b. Signature and title of certifier	29c. License O.C.M		29d Date signed (Month, Day, Year) September 10, 2006
20		30. Name and address of person who completed cause of death (Item 2 Jack Titus MD. Deputy Chief Medical Examiner		more, MD 21201	
Regis	State		e		

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar		aryland / D	epartme Certifica	ent of He ate of D	ealth and I Death	F	leg. No.	106	28881
46	Physici /Medic		Decedent's Name (First, Middle, La:     Mary Carol	Turano					2. Date of Dea Month Sept.	Day 11,200	Year 5	3. Time of Death 7: 20am
	Examin		4a. Facility Name (If not institution, giv. 1900 Beeches Glo				ity, Town, or l Innapo]	ocation of Death		4c. County Anne		de1
	Funeral Director		310 70 7003	ex 7. Ag ☐ M 2 🔀 F	e (In yrs. last birth 45 Y	Montl	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 19	, Year) 9,1961	9. Birthp Cou	olace (State or Foreign ontry) Harve MT
	Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne An	runde1	10c. City, Town	or Location apolis	5				,	0d. Inside City Limits 1   Yes 2 □ No
	with the	Director	10e. Street and Number 1900 Beeches Glo	orv Path		10f.	Zip Code 21401			10g. Citizen of	What Cou	ntry?
920	be filed within 72 hours after death with the Maryland by yielde. By by yielde by the world of by the me 23a or 28a-f show of other then "natural", or items 23a or 28a-f show event, I're Medical Exeminer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:					pecify Yes or No- pecify Yes or No- pecify Yes or No-		ck, White,	ean Indian, etc. ite
21215-0036	c = 39	Completed	15. Decedent's E. (Specify only highest gra		54)	Give kind of life. DO NO	Tuse retired)	tion uring most of wor Safety	king	16b. Kind of B		dustry ecurity
Maryland 2	should be filed withir and Mental Hygiene. Ie marked other then eumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last, Raymond Mehrar					18. Mother's Nam	ne (First, Middle, Telling		ne)	
	D € Z €		19a. Informant's Name/Relationship ( Tim Turano / Hus	• • • • • • • • • • • • • • • • • • • •		_			ral Route Numbe ath Anna		,	· ·
Baltimore,	Pages 1 ar nent of Hea int: if item: iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 2 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of E cometery. Maplehi	crematory	or other place	Sept 2006	Date 14,	20c. Location Archbald		own, State
Balti	permit. Pages i Department of H Important: If its eny injury or of suce.		21. Signature of Funeral Service Licer	nsee		Char	and Address les L. S East R	Stevens Fu	neral Hom Baltimore 1	e Inc. MD 21230		
	Cate be executed / Medical Examiner and physician and the private transit street the private transit street be executed with the physician and the physician	ai Examiner	23a. Part1. Enter the disease, or composed to the control of the c	a. Due to (or as b. Due to (or as c.	a consequence of	): ):		, such as cardiac	or respiratory and	rest,		Approximate Interval Between Onset and Death
O. Box (	Physicien: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death	3 □Ectopii 5 □ Other	c pregnancy (specify)				te of delive	ery Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in t	the underlyin	g cause giver	n in Part I.				ne cause of death?
Il Records,	The law require sate has been si page 2 should t	Completed							24a. Was a autop perfor 1 Yes	med?	Were auto prior to co death? 1 🗌 Yes	psy findings available mpletion of cause of
of Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospitat:	ent 2 ER/Outp		DOA Other		th (Check only or			
of	ding Phys n. After this funeral di	): To	1 ☐ Yes 2 € No  27. Manner of Death	4   Nursing H	ome 5 Resid			y)				
Division		Certification:	27. Manner of Death  1								per or Rura	d Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medicai C	29a. Certifier (Check only one)  Certifying Phone 2 Medical Example 1	ysician: To the best niner; On the basis o and manner st	f examination and/	death occurr or investigat	red at the time ion, in my opi	e, date and place nion, death occu	, and due to the or rred at the time, o	ause(s) and mate and place,	anner as s and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	Wolfm.	hm		29c. License			SENT		
	6		30. Name and address of person who STANURY WA	completed cause of o	900 (	ype, Print)	SATE	PD 1	ANNAI	Idlis	m	2006
3.77	Sta		31. Date filed (Month, Day, Year) CED 1 2 2006	32. Registr	ar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200628882 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Philip A. Whitcomb, Sr. September 6, 2006 5:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3901 Annapolis Road Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. (Month, Day, Year)

Aug. 1, 1942 5. Social Security Number 9. Birthplace (State or Foreign X□M 2□F 214-38-3983 Maryland Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901. Annapolis Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Whitcomb Carrie Grace Weenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Whitcomb - Wife 3901 Annapolis Rd., Caltinore, MD 21227 20b. Rlace of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
eny injury or ott 1 Burial 2 Cremation 3 Removal from State 9-11-2006 4 🗀 on tion Sign a slat West Arundel Crematory Odenton, MD 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final HEDATIC Few changs FAILURE disease or condition resulting in death) Due to (or as a consequence of) CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy Day 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Acsidence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

/Medical Examiner physician and the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records,

After thi Certification: ospiter Constant Africation of Processing Street Constant Stre 24 hours a within 24

**Funeral** 

r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at

27 is marked othe traumatic event,

other

**Physician** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter if item 27 is marked other than "natural", or items 23e or 28e-f show

Baltimore, Maryland 21215-0036

State Registrar

MATERN AW AN 31. Date filed (Month, Day, Year) SEP 1 2 2006

investigation

6 Could not be determined

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EERRY RUAD BALTIMORE MD 21227 HAMMONDS

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

М

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madrea Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)0062634

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For Amend Registrar	d item#31,pe	State of MerDVR,G859,	laryland 9/12/06	/ Depa	artment rtificate	t of He e <i>of D</i>	ealth and l leath	Mental Hy	/gien	<sup>e</sup> 200	5 28	883
	Physici /Medic			e (First, Middle, Last an E. Wa							2. Date of D Month Sept.		2006 Year	3. Time (	of Death 25 M
4	Examir			not institution, give Chesapea			ente			ocation of Deat.	h	40	County of Dea Har	ford	
	Funeral Director		5. Social Security No. 228-58-	umber 6. Se -2387 1		ge (In yrs. Ias 63		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi July 2	irth Year	9. Bii Ma	thplace (State ountry) ryLand	or Foreign
	yland how		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo							10d. Inside (	
	the Ma 28a-f s	recto	MD 10e, Street and Nun	Harfo	ora 		50	ppa 10f. Zip	Code	·		10a. C	itizen of What C		s 2 <b>X</b> No
	ath with	Funeral Director	1904B Mc	ountain Ro					2108	35			itizen of What C USA		
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGs.	Ď	11. Marital Status 1 ☐ Never Marrid 3 ☐ Widowed	ed 2 <b>∏M</b> Married 4 □Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	1	Was Decedd f Yes, spec I ☐ Yes 2	ify Cuban	panic Origin? (S Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Am Black, Whi Specify:Whi	te, etc.	
21215-0036	in 72 h	Completed		15. Decedent's Edu ify only highest grad	e completed)		16a. Deced (Give life. L	lent's Usua kind of wor OO NOT us	l Occupat k done du e retired)	ion ring most of wo	rking		Kind of Business		
	led with lygiene. her the		Elementary/Secon		College (1-4or	5+)		airma	n				ito Bodi	Shop	
lanc	uld be fi Mental H rked ot tic ever	To Be	17. Father's Name ( Edwin I	P. Wassum							ne (First, Middle [. Harri				
, Maryland	and 2 sho salth and h n 27 is me er traums	0.000		me/Relationship (T)			19b. Mailin 1904B	g Address Moun	(Street an	d Number or Ru Road–Jo	oral Route Numb Oppa, Mar	ber, City Cylar	or Town, State, nd 21085	Zip Code)	
Baltimore,	Pages 1 ament of He ent: If Iten ury or oth			osition Cremation 3 F 5 Other (Specify)		20b. Placent	ce of Dispo netery, cren INVIEW Gar	sition (Nam natory or oth Memo dens	ne of herolace priat	9–12	Date 2–06		ocation - City or Llston, N		d
Balt	permit. Departi		21. Signature of Fu	neral Service Licens	Eval	D	3	. Name and	Address ort D	of Facility FVZ rive-Fol	WS <sub>t</sub> FUNE	RAI H	HOME aryland	21050	
			23a. Part 1. Enter the shock, or head Immediate Cause (	disease of come allure. List only of Final				er the mode	of dying,	such as cardiad	or respiratory a	arrest,		Approxima Interval Be Onset and	btween Death
	Physician /Medical Examiner		disease or condition resulting in death)	•	Due to (or as	a conseque		lu	5	Can	-e-			6 m.	s aths
		Jer	Sequentially list con	nditions,	b. Due to (or as	a conseque	rice of).								
	xecuted and al-transi	Examin	if any, leading to im- cause. Enter Under Cause (Disease or in that initiated events resulting in death) L	injury ast	c Due to (or as	a conseque	nce of);							_	
68760,	icate be executed physicien and the burial-transit	dical			d.										
P.O. Box 6	The law requires that the death certifics are hes been signed by the attending pt bage 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3□	Ectopic pre Other (spe					23d. Date of de Month	livery Day	Year
	luires that n signed bi	þ	Part II. Other signifi	cant conditions co	ntributing to death	out not resulti	ing in the ur	ndertying ca	tuse given	in Part I.		tobacco Yes 2	use contribute t		death?
Records,	The law requisete hes been page 2 should	Completed				·						opsy ormed?	prior to death?	utopsy findings completion of	s available cause of
Vital		Be	25. Was case referr examiner?	-	Hospital:						1 ☐ Yes			2 No	
o	Phys rahdii	n: To	1 Yes 2	1	28a. Date of Inj (Month, Da	ury 2	NOutpatien 8b. Time of Injury		A Other Bc. Injury a Work?	4   Nursing H	ome 5 ☐ Res 28d. Describe		6 Other (Spe	icify)	
Division	Attending ir death. ector: After by the fune	Certification:	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be determined	28e. Place of In			М	1 □ Ye	es 2 🗆 No	28f. Location	(Street a	nd Number or R	ural Route Nur	nber.
ģ	urs after orat Dire		4  Homicide			tc. (Specify)					City or To				
	To the Hospitel or Attendi within 24 hours after death. Ye the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner s	of examination	edge, death n and/or inv	occurred a restigation,	it the time in my opir	, date and place tion, death occu	, and due to the irred at the time	cause(s , date an	and manner a d place, and due	s stated. e to the cause(	s)
	To with	Σ	29b. Signature and	title of certifier	Silver of the second				License i		SE	29d. Da	te signed (Moni	th, Day, Year)	
	5		30. Name and addre	ess of person who co	ompleted cause of		3a) (Type,	Print)	. ها)	roneuls	· h- 1	3el	Air M	2 510	(4
-5	Sta Registr	_	31. Date filed (Mont	h, Day, Year)	32. Regist	rar's Signatur	re	19000	. d.P. d	H do	eh-1				/
18	- I legion	211	110	5100		114	L000	The state of the s	A Company of						

20/01/10

Jassum, Norman 4 160875

	Db.		1 - For State Registrar  1. Decedent's Name (First, Middle, La					2. Date of De		3. Time of Deat	n
	Physic /Medi		Andrew F. W					septen	<i>'</i> — —	2006 3:365	<sup>'</sup> M
	Exami	ner	4a. Facility Name (If not institution, given the Sa	e street and number) peake			Location of Death		4c. County		
				ical Center	rs. last birthday)	Be If Under 1 Year	l Air	8. Date of Bin		rford	
	Funeral Director			¥⊒M 2□F 82		Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Fore Country)	Ngn
	<b>P</b>		Usual Residence of Decedent				l	6/23/	1924	Maryland	
	anylar ehow	-	10a. State 10b. County		City, Town or Lo					10d. Inside City Lin	
	with the Maryland a or 28a-f ehow	ecto	Harfo	ord		rrettsv	тте	1		1  Yes <b>22</b> 🔀	40
	with I	5				10f. Zip Code			10g. Citizen of	What Country?	
	deeth v me 23s	era	1531 Baldwin I	12. Was Decedent Ever in	n U.S. 13.	2108 Was Decedent of Hill If Yes, specify Cuba		ecify Yes or No	US/ - 14. Rad	A ce - American Indian,	
036	or to	by Funeral Director	1 ☐ Never Married 2 ☐ Married  ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※ ※	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes <b>X</b> XNo		Rican, etc.)	Specif	ck, White, etc.  White	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of B	usiness/Industry	
22.	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	i)	,,,,,	Heav	y ipment	
<u>Б</u>	s 1 and 2 should be filed with if Heelth and Mental Hygiene. Item 27 is marked other ther other traumatic event, ILB M	Be C	17. Father's Name (First, Middle, Last			CCHAILE	18. Mother's Name	e (First, Middle,			
ylar	2 should be n and Mental is marked o reumatic eve	ToE	Charles M. V	Vhitney			Sophi	a M. F	oster		
○ (	2 sho and is mu		19a. Informant's Name/Relationship (			ng Address (Street a					
_	1 and 1 Heelth em 27 ther tr		Raymond A. Whit		901	7 Satyr				MD 21234	
ر م more	Page ment o ant: if ury or		Maurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Control	Removal from State	Highvi Gar	matory or other place ew Memor dens	Sept Sial 200	6	Fall	City or Town, State	
Balt	permit. Departimport. any nj		21. Signature Juneral Service Lice	SILL		2. Name and Addres	ss of Facility 3 neral Ch	Newpo	rt Dr. Bel Ai	Forest Hi	L1
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a. 1		piration	<b>FUGUIIO</b>	La		Onset and Death	10
~	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		•				
1		je je	Sequentially list conditions,	b. Due to (or as a cons	equence ul :	1124	C010)			Succe	3
7	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		1.00						
00	ate be executed hysicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a cons	equence of):						
3 8760	ate be physicie the bur	dical		d							
Q 20	certific Iding pl	Med	IF FEMALE:								
.o. Boy	v requires that the death certific been signed by the ettending p should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of prec  1 Live birth 2 Fe  4 Pregnant at time o  9 Unknown	etal death 3[	Ectopic pregnancy Other (specify)				te of delivery nth Day Year	
20°	s that med b e deta		Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to the cause of death?	
S. E.	w require been sig should b	pa	Debilita	Sever	- Ma	(noutro	tion	1 🗆 Y	es 2□No	3 Probably 4 Unkno	₩n
Anc		Completed by	Stage For	v Sacra	( De	Enbit	is Ulce	perfor	med?	Were autopsy findings availal prior to completion of cause of death?	ole of
-E	ian: rtifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Death		-	I ☐ Yes 2 No	
న≥	hysic his ce Il dire	P	12 Yes 2 □ No		☐ ER/Outpatien	t 3 DOA Othe	or: 4 🗆 Nursing Ho	me 5 ☐ Resid	lence 6 🗆 Oth	er (Specify)	
+U	ding I	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date o Injury (Month, Day Year)	28b. Time of Injury	Work	at ?? Yes 2 □ No	28d. Describe h	ow injury occurs	red	
Jivis	or Atter	Certification;	3 Suicide 6 Could not b 4 Homicide determined		home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural Route Number,	
	To the Hoepital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical Ce	Check only Z   Medical Exar	ysician: To the best of my k	nowledge, death	occurred at the tim	e, date and place,	and due to the o	ause(s) and ma	unner as stated.	
3	DM T	Q	0.10)	and manner stated.		29c. License				d (Month, Day, Year)	
3	thin (	₹ S	29b. Signature and title of certifier						Loui Date signet		
3	To the within 7 to the comple	Me	29b. Signature and title of certifler	MIT		7	ハマファノ	2			,
3	160.	Me	1 an	OTTO Fied cause of death (III	em 23a) (Tvne	Doc Print) 500		S	Serter		Ś
3	To the within To the complex	Me	1 an	compried cause of death (It	tem 23a) (Type,		25356 Uper	9-7	, 0	rber 2, 200	<b>\</b>
3	12X	ate	1 an	1 homes	MICO	Print) 500		Chese Mors	, 0		5
3	124	ate rar	30. Name and 30055 0 1 Miles 31. Date filed (Month Qay, Year)	Thomas	MICO	Print) 500		9-7	, 0		6

ORIGINAL

Valerie J	cy	Wolfe	
UNK UNK		Please Type or Print in Black Indelible Ink  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Registrar	g. No. 2006 2888
Physicia Medical Exami	ın/	Valerie Joy Wolfe  2. Date of Death Month August 28,	Day Year 1935 hrs
		4a. Facility Name (if not institution, give street and number)  2000 Blk. Ashbuton Street  4b. City, Town, or Location of Death  Baltimore	4c. County of Death
Funeral Director		3715-67-0133	h (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
d how any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Unk Unknown Unknown	10d Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code Unknown	g, Citizen of What Country?
er death with	Funeral	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No  3 Widowed  4 X Divorced If Yes, Give Year  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ret of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  12 College (1-4 or 5+)  Unknown	16b. Kind of Business/Industry Unknown
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Comp	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Name (First, Middl	
D 212 should b and Men 7 is marl	ToE	19a. Informant's Name/Relationship (Type, Print)  Alton V. Wolfe/ex-husband  19b. Mailing Address (Street and Number or Rural Route Num  503 Perry Ct. Edgewood	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Crematory or other place)  4 Donation 5 Other Specify.  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory 9/11/06	20c Location - City or Town, State  Beltsville MD
Baltir permit F Departme Importar injury or		20 Signature of Funeral Service Licensee  22. Name and Address of Facility CAFA  23. Name and Address of Facility CAFA  24. Name and Address of Facility CAFA  25. Name and Address of Facility CAFA	r. Baltimore MD
Physician /Medical ∉ ⊊xaminer		23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrefailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. No identifiable anatomic or toxicologic cause of deat output (or as a consequence of):	Between Onset and
<b>V.</b> J	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):  Due to (or as a consequence of):  c.  Due to (or as a consequence of):	
executed in and il - transit		d.	_
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer date. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medica	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d Date of delivery  Month Day Year
P.O. E es that the consigned by the detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to	bacco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
Division of Vital Records, ta or Attending Physician: The law require in Director After this certificate has been silled in by the funeral director, page 2 should be	Completed	24a. Was a autop perfor	sy prior to completion of cause of med? death?
of Vital Rec iing Physician: The After this certificate funeral director, page	o Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5	Residence 6 🗸 Other Scene
on of ording Pluth.	tion: T	1 Natural 5 Pending Find 8/28/2006 1mk	now injury occurred
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	ertification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (\$	Street and Number or Rural Route Number, City tate) 2000 blk. Ashburton St
To the Hospi within 24 hou completely fi	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus (neck only one)	e(s) and manner as started
To wit To con	Mec	29b. Signature and title of certifier  Potter August Pollulus  29c License number  O.C.M.E.	29d. Date signed (Month, Day, Year) August 29, 2006
		30. Name and address of person who completed cause of death (Item 23a)	

State Registrar DHMH 17 Rev 1/2001 OCME 2006

Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 2006

ORIGINAL

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

		1. Decedent's Name (First, Middle,				icale of	Douth	Mental Hy			3. Time of Death
Physici		Jerome	Luoiy	1.	lashin	atria		Month AUG	Day 28	2006	3: 10AN
/Medi Examir		4a. Facility Name (If not institution,	give street and nun		41	b. eity, Town, o	r Location of Dea			ounty of Death	0
LXUIIII	1101	ST. AGNES HO	SPITAL			BALTIN	MORE	•		NIA	•
Funeral		Social Security Number		7. Age (In yrs. la	M	f Under 1 Year Ionths Days	If Under 24 Hr Hours Mir		th v, Year)		lace (State or Foreign
Director		213-70-1274	1 <b>5</b> 2 M 2□F	49	Yrs.			08/22/1	957		MS
and		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Locati	ion				1	0d. Inside City Limits
Mary	ō	MA MI	A	30	Itimo	12					1 XYes 2 □ No
ours after death with the Maryland 'al', or iteme 23a or 28a-f ahow Exantrar mast be notified at	Director	10e, Street and Number		JOA		10f. Zip Code			10g. Citize	n of What Cour	itry?
h with	<u>e</u>	2700 W. Poto	apsco A	tre		21230				NIA	
	Funeral	11. Marital Status		edent Ever in U.S		s Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No	- 14	Race - Amend Black, Whife,	
or its	Fu	1 ☐ Never Married 2 🛱 Married		2 1 No		Yes 2□Xio	Specify:	nto riloani, oto.,	S	pecify: 2/	erc.
natural',	d by	3 Widowed 4 Divorced	Year or Da	ates:						010	CK
n 72	Completed	15. Decedent's (Specify only highest			(Give kind	t's Usual Occup d of work done NOT use retired	during most of w	orking	16b. Kind	of Business/Inc	dustry
filed withii Hygiene. ther then	l mc	Elementary/Secondary (0-12)	College (1	-4or 5+)	0	stodi	•		H	senito	. )
filed with Hygiene other the	60	17. Father's Name (First, Middle, La	ast)			5 10011		ime (First, Middle,	Maiden Si	umame)	
should be filed within 72 hours atter nd Mental Hyglene. I marked other then "natural", or ite umatic avent, the Medical Examira	To B	James Wast	ningtor	1			Rosec	bell	Mo	ick	
es 1 end 2 should be fi of Health and Mental H f Itam 27 is marked ott r other treumatic ever	-	19a. Informant's Name/Relationship	p (Type, nnt)		19b. Mailing A	Address (Street		lural Route Numb	er, City or 1	Town, State, Zip	Code)
end 2 saith a n 27 is		John Dur	ham		1217	Silv	erthori	ne Roa	d	Balto.	MD 2123
of He of He fitem r oth		20a. Method of Disposition  1 Disposition  2 Cremation  3	3 Demoval from 9		ace of Disposition	orv or other plac	(e)	Date		tion - City or To	wn, State
Pag nent ant: i		4 Donation 5 Other (Spe		Tri	inity	Cemet	ery 9-	5-06 n.11.11	Dune	talk.	MO
permit. Departr Importa eny injugan		21. Signature of Funeral Service Lic	icensee	-	22. N	ame and Addre	ss of Facility	n.11: V	1	,	2121.
% ō E ≅ a		· omupp u	rath	erpo	11/00	there	d Trune	val Sel	V. 24	131 E.O	1:12/51
		On Daniel Enterthandinger on a			0000	-, -, -, ,	7				
		23a. Part1. Enter the disease, or or shock, or heart failure. List or	complications that cannot one cause on ea	aused the death ach line.	. Do not enter the	he mode of dyir	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on ea	aused the death ach line.			-				Interval Between Onset and Death
Medical		shock, or heart failure. List or Immediate Cause (Final	a. SQU	ach line.	S CEL		-	oc or respiratory a			Interval Between Onset and Death
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/Medical examiner	niner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. SQU Due to (	ach line. JAMOU	S CFL sence of):		-			1	Interval Between Onset and Death
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Medical  Medical  American  Medical  Me	dical Examin	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulfing in death) Lasf	a. SQ Due to (	or as a consequ	sence of):		-				Interval Between Onset and Death
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Medical personal pers	dical Examin	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulfing in death) Lasf  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	a. SQ Due to (c) b. Due to (c) c. Due to (c) d	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of de	ence of):  sence of):  sence of):		CER (		DAT		Interval Between Onset and Death ONE KNOW
death certificate be executed  e attending physicien and ad for use as the burial-transit	dical Examin	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulfing in death) Lasf  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. SQ Due to (c) b. Due to (c) c. Due to (c) d. 23c. If yes, outded to the pregnance of the	or as a consequence or as a consequence of pregnar inthemoly 2 Fetal ant at time of decomposition.	ence of):	topic pregnancy, ther (specify)	CER (	FTHR	DAT	Month	Interval Between Onset and Death Onset and Dea
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State of Maryland / Department of Health and Mental Hygiene 2006For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** JAMRS W. 150N 2006 3:07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner B91 -14-ION JECKURS Huspital If Under Year | If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 €M 2 □ F 56 Yrs Director JUNE 22,1950 MD 214 54 5147 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow r than "nature!", or freme 23a or 28e-f ehov the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD. N/A baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 21205 USA 913 IRIS AVENUE Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whife, efc. 11. Marital Status filed within 72 hours after HYes, Give Year or Dates: MARINE CORP. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nu eny injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) Colfege (1-4or 5+) 12th ROOFING ROOFER CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES WILLIAM WILSON, SR. LULURENE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATINA WILLIAMS(daughter) 2211 ST. PAUL STREET BALTO, MD. 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Sfate 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY SEPT. 13,2006 BALTO, MD. Algnature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 PRESTON ST.  $\mathbf{E}$ BALTO MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit signed by the attending physician and de detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably bleen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No after deeth.

Director: After this certific
Jin by the funeral director, 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 2 NOutpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury af Work? 28d. Describe how injury occurred Certification; 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - Af home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an, man BR7794832 eptember 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 123B12001

State Registrar 31. Date filed (Month, Day, Year)

2 2006 2000 WEST

Baltimure

MD

32. Registrar's Signature

			1 - For State Registrar	State o	f Marylan	•	artment of H		Mental Hygi	ene 2 (	006	28888
			Decedent's Name (First, Middle, L.)	ast)					2. Date of Death			3. Time of Death
	Physici		GWENDOLYN W	TMVTED					Month	Day	Year	11:00 MAM
	/Medic Examin		4a. Facility Name (If not institution, gi		mber)		4b. City, Town, or	Location of Deat	August 30	4c. County		1
	LAdiiii	le i	Prince George's				Cheverly			PG		
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		577-66-7622	1 ☐ M 2 🛣 F	56	Yrs.	Months Days	Hours Min.			Cour	ngton.DC
	ס		Usual Residence of Decedent						Dep. 23	1747	Washi	iig con , DC
	ylan how		10a. State 10b. County			y, Town or Lo					1	0d. Inside City Limits
	Ma P-f	ş	MD 1	P.G.	Bra	ndywin	e					1√2 Yes 2 No
	h the 28	ire	10e. Street and Number			· ·	10f. Zip Code		10	g. Citizen of	Whal Cour	itry?
	death with the Maryland me 23a or 28a-f ehow r must be notified at	ai	6709 Burch Hill I	Road			20613			US		
	be filed within 72 hours after death with the Marylan ital Hygiene. Indoorber then "naturel", or Itame 23a or 28a-f show event, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		e - Americ	
9	or It	2	1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	2 X No		T ☐ Yes 2X No	Specify:	10 (11041), 510.,		у: В1а	
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a Z	C/ C/ = 6		19a. Informant's Name/Relationship	(Type, Print)					ural Route Number,		State, Zip	Code)
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	Pages hent of H		1 ☑Burial 2 ☐ Cremation 3 (	☐Removal from	State		sition (Name of natory or other place			Oc. Location	•	own, State
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n n	permit. Pages Depertment of I Important: If it any injury or o		21. Signature of Funeral Service Lice	ensee	all	3	. Name and Addres. 89 Rhode	s of Facility $\mathrm{F}$ $\mathrm{Island}A$	razier's Fur Ave.,NW, W	eral Ho Wash.,	me, In DC 20	c. 0001
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18	cuted nd ransi	Examine	Cause (Disease or injury that initiated events	c.H. er	tension							
Š	exe en ar rial-t		resulting in death) Last	Due to	(or as a consequ	uence of):						
g/on,	certificate be executed nding physicien and use as the burial-transit	cai		_ d								
0	ntifica ng ph as th	Jed	IE EEMALE.			-						
X Q Q	<ul> <li>requires that the death certific</li> <li>been signed by the attending f</li> <li>should be detached for use as</li> </ul>	an/	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy				te of delive	,
	death or atten	slci	in the past 12 months? 1 ☐ Yes 2 ※☐ No		ant at time of de		Other (specify)			Mo	onth	Day Year
5	requires that the leen signed by th hould be detache	h.	9 Unknown									
ď.	gned be de	by 6	Part II. Other significant conditions			•	, ,		23e. Did toba	cco use con	tribute to th	ne cause of death?
<u> </u>	equir en si ould	ted	Cerebrovascular	Acciden	<u>t</u>	Bline	d Right E	ye	1 🗌 Yes	2 □ No	3 Prob	ably 4 GUnknown
Hecords,	E 25 B	Completed by Physician/Medical	Diabetes Mellito	s		Feed:	ing Disfu	nction	24a. Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of
	The law ete has b page 2 s	PO.	Depression						performe 1 ☐ Yes 2	ad?	death? 1 ☐ Yes	
VII	etor.	Be (	25. Was case referred to medical examiner?					26. Place of De	ath (Check only one,			
	nysic lidire	To	1 ☐ Yes 2 ☐ No	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3X DOA Othe	C 4 Nursing h	Home 5 ☐ Residen	ce 6 □Oth	er (Specif	1)
o U	ng Pl fter ti	ü	27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occur	red	
0	endii eath. or: A he fu	ati	2 ☐ Accident investigation	on			M 1 7	'es 2 □No				
DIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	1 286. Place	of Injury - At ho ing, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Numb State)	per or Rura	l Route Number,
2	rs af	Ce		1								
	To the Hospital or Attending Physicien: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the b	asis of examina	wledge, death tion and/or inv	n occurred at the time restigation, in my op	e, date and place inion, death occi	e, and due to the cau urred at the time, dat	ise(s) and mi	anner as st	ated. the cause(s)
	thin 2 the mpiel	Med	29b. Signature and title of certifier	and man	ner stated.		29c. License			d. Date signe		
,	S S S S	_	AA 4 A	11/10		6		2435	1	Augus 1		
	,/		Juguenilla	Ld/U	July 1	7/	)					
	り		30. Name and address of person who									
			11120 New Hampsl 31. Date filed (Month, Day, Year)		enue –		r Spring,	בונו בעו	904			
	Sta Registr		SEP 1 2		adistral a digna	la la	The state of the s					
			SEP 1 Z	2000	A. 345.8	All A						

			For State Registrar		State of	Marylar		artment rtificate		ealth and Death	Mental Hy	giene Reg. No	2000	28889
	Physici	an	1. Decedent's Name (First, Midd		T	Charre	na III.i	•			2. Date of D Month	Da	y Year	3. Time of Death
E	/Medic Examir		4a. Facility Name (If not institution				ens Whi		Town, or	Location of Dea			10, 2006  County of Death	
W.		) (	Maplewood Par 5. Social Security Number	k P1			are last birthday)	If Under	В	ethesda If Under 24 Hrs		rth		gomery place (State or Foreign
ř.	Funeral Director		578-07-1212 Usual Residence of Decedent	10	M 2 <b>X</b> ) F	95	Yrs.	Months	Days	Hours Min	October	24,	1910 Wash	ington, D.C
	yland now		10a. State 10b. County	,		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	Be-f st	Funeral Director		ntgo	mery			T		ethesda				1 ☐ Yes 2 📉 No
	with ti	Dir	10e. Street and Number					10f. Zip	Code			10g. Cit	tizen of What Cou	intry?
	eath s 23,	erai	9707 O1d			n Road dent Ever in U	18 13	Was Deced	lent of Hi	20814 spanic Origin? (S		- 1	United 14. Race - Ameri	
920	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Itams 23a or 28e-f show avent, the Madical Examinar must be notified at	by	1 Never Married 2 Ma 3 X Widowed 4 Divorce	ried	Armed For 1 Yes If Yes, Give Year or Da	ces? 2 📉 No e		f Yes, spec	rfy Cuba	Specify:	to Rican, etc.)		Black, White Specify:	
0	72 ho	ted	15. Deceder				16a. Dece	dent's Usua	I Occupa	ution furing most of wo	rking	16b. K	ind of Business/Ir	
Maryland 21215-0036	filed within 7 Hygiene. other then "r ent, the Mad	Completed	Elementary/Secondary (0-12)	isi grade	Cotlege (1-	-4or 5+)	life.	DO NDT us	se retired,	aker	rking		Own I	lome
b	be filed tal Hygid d other avent, ti	Bec	17. Father's Name (First, Middle	Last)						18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
ylar	should be nd Mental marked o	ToE			B. St	evens							Callagha	
Jar	. a . 3		19a. Informant's Name/Relation					-				,	or Town, State, Zi	
	s 1 and 2 f Health item 27 i		Robert S. Wh	ite/	Son	20h	100 Place of Dispo			Drive,	Vienna Date		cginia 2:	
mor	0 0		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (		moval from S	State ]	Gemetery, creation to the control of	natory or of ery	ther place	Sept	ember 2006		•	Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fundal Service	License	-/	A M00					bert A.	Pump	hrey Fur 7 Wiscon	neral Home/ nsin Avenue
V. 3			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complic	ations that ca	used the dea	th. Do not ent	er the mode	e of dying	g, such as cardia	c or respiratory	arrest,	T	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.			Heart							Onset and Death
	/Medical Examiner		resulting in death)		Due to (	or as a consec	quence of):							
	7.8	Jer	Sequentially list conditions, fig. any, leading to immediate.  Due to (or as a consequence of):											
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Dura ta (									
8760,	cate be executed physicien and the burial-transit	aiE	,	1	Due to (c	or as a consec	quence or);							
687	ificate p physics the	edicai		d.										
.O. Box	at the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23	1 Live bi	come of pregn rth 2 □ Feta ant at time of a wn	aldeath 3[	Ectopic pre Other (spe					23d. Date of deliv Month	rery Day Year
<u>α</u>	gned be de	þ	Part II. Other significant condit	ons cont	nbuting to de	ath but not re	sulting in the u	nderlying ca	ause give	on in Part I.			_	the cause of death?
Vital Records,	The law requir ate hes been si page 2 should	Completed										psy ormed?	prior to co	opsy findings available omptetion of cause of
ta		0	25. Was case referred to medical	al						26. Place of De	1 ☐ Yes ath (Check only	2€ No oneJ	1 Yes	2010
2	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Ho	spital:	patient 2	]ER/Outpatier	t 3 DO	A Othe	AC			6 ☐Other (Speci	fy)
ion of	ding h. After fune		27. Manner of Death  1 X Natural 5 Pendi 2 Accident invest	ng igation	28a. Date o (Monti	f Injury h, <i>Day Year)</i>	28b. Time o Injury	M 2	8c. Injury Work	at	28d. Describe	-		
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten			of Injury - At h g, etc. (Speci	iome, farm, str fy)	eet, factory	, office		28f. Location City or To			al Route Number,
	To the Hospitel or within 24 hours affer To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physi I Examin	cian: To the er: On the ba and mann	sis of examina	owledge, deatl ation and/or in	occurred a	at the tim in my op	e, date and plac pinion, death occ	e, and due to the urred at the time	cause(s date and	and manner as s d place, and due t	stated. to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certific	er	7	no	<b></b>	29c	License	number		29d. Da	te signed (Month,	Dey, Year)
)	<		1//	1	4	19	10			D26259		S	September	11, 2006
•	7'		30. Name address of person						C	±0 102	Poth	lo 24	[amr-1 = - 1	20017
	Sta	ite	Ava Kaufman, 31. Date filed (Month, Day, Year	)	9218 32. Re	W⊥SCO1 egistrar'≸ \$ign	nsin Av	enue,	Sul	.ce 103,	betneso	a, M	ıary⊥and	20814
	Regist		SEP 1 2 200	16	Car Alea	a At	13							

			For Stete Registrar	State of N	Maryland / Depa Ce	artment of H			iene <sub>9g. No.</sub> 2006	28890
	Physici /Medic		1. Decedent's Name (First, Middle, La  Ada B. Wilhoit	st)				2. Date of Deal Month Sept 7,		3. Time of Death 11:35 PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. County of Death	
	Funeral		Westminster Nur: 5. Social Security Number 6.5		Rehab <sup>Age (In yrs. last birthday)</sup>	Westmir	If Under 24		Carroll	place (State or Foreign
ì.	Director		217-20-9024	I□M <del>2</del> EXF	89 Yrs.	Months Days	Hours	Min. (Month, Day, Dec 15,	1916 TN	intry)
	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary e-f sh	ctor	Maryland Baltimo	re	Baltimor	e				1 ☐ Yes 2 ☑ No
	or 28	Direc	10e. Street and Number			10f. Zip Code 21144			Og. Citizen of What Cou	
	eath v	Funeral Director	9206 Clays Lane A	12. Was Deceder	nt Ever in U.S. 13.		lispanic Origin		United Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic event, If a Medical Examinar must be notified at once.	y Fun	1 Never Married 2 Married 3  Widowed 4 Divorced	Armed Forces  1 Yes 2  If Yes, Give Year or Dates	NO I	If Yes, specify Cub 1 ☐ Yes 2√☐ No	an, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, White	
0	2 hour	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business/Ir	
215	ithin 7; Nan "n	nple	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4o	r 5+)	kind of work done DO NOT use retire	during most o d)	f working		·
7	iled with the the the the the the the the the t	Cor	12th 17. Father's Name (First, Middle, Last	1	Homem	aker	18 Mother's	Name (First, Middle, I	her home	
Maryland 21215-0036	should be f nd Mental h marked of	To Be	Albert Smith	,				1. Ottinger		
lary	2 shou and M Is mar	-	19a. Informant's Name/Relationship	Турө, Print)			and Number	or Rural Route Number	, City or Town, State, Zi	p Code)
	1 and 1 tealth sm 27 ther tr		Jim Wilhoit (son) 20a. Method of Disposition			-		Indsor, MD	ZI//6 20c. Location - City or T	own State
mor	Pages nent of I nt: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, crea Lorraine				oodlawn, MI	
Baltimore,	permit. I Departm Importer any injus		21. Signature of Funeral Service Lice		22	2. Name and Addre	ss of Facility		and Cremate	
	70 F # Ø		23a. Part 1. Enter the discase, or com	inlications that caus						
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	line.	la an	e11.	<i>k</i>		Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or a	as a consequence of):		un	land se		2000
	LAMITME	-G	Sequentially list our dillors, if any, leading to immediate	Due to (or a	ursulus a consequence of):	otre !	Mac	day dise	en	25%
	cuted id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
30,	icate be executed physician and s the burial-transit	i Exa	resulting in death) Last		as a consequence of):					
68760,	ficate b physic s the b	edical		_ d						
Box (	death certifica attending phate as the	m/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy	,		23d. Date of deliv	ery
о. Ш	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/M	in the past 12 months? 1 □ Yes 2 I No 9 □ Unknown		at time of death 5	Other (specify)		<del></del>	Month	Day Year
٥.	ires that the signed by does de detac	by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the u	- nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ords	w require: been sig should be	ted b						1 ☐ Y∈	es 2. KNo 3 □ Prol	bably 4 □Unknown
Vital Records,	e faw r has be je 2 sh	Completed						24a. Was a autops perform	y prior to co	opsy findings available empletion of cause of
ta F		e Co	25. Was case referred to medical				26 Place of		No 1 ☐ Yes	2□ No
	Physician: this certific	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpatier	nt 3 DOA Ott	er .		nce 6 □Other (Speci	fy)
n of	ding Ph h. After thi funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, E	jury 28b. Time o Day Year) Injury	Wor	'k?		ow injury occurred	
Division	or Attending I after death. Director: After in by the funer	Certification:	2 \( \bar{\Delta} \) Accident investigation 3 \( \bar{\Delta} \) Suicide 6 \( \bar{\Delta} \) Could not be determined	e 28e. Place of I	njury - At home, farm, str		Yes 2 □ No	28f. Location (St	reet and Number or Run	al Route Number,
ă	ital or A	Cert	4  Homicide determined	building,	etc. (Specify)			City or Town	n, State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysicien: To the bes niner: On the basis and manner:	st of my knowledge, deat of examination and/or in stated.	n occurred at the tir vestigation, in my o	me, date and p pinion, death	place, and due to the ca occurred at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Month,	Day, Year)
•	,		Johns	ndlut	~ MD	DL	544	}	1/8/500	76
	6		30. Name and address of person who	ik Kles	death (Item 23a) (Type.	rinti vie R	ont.	Weston	isten M	DZIITZ
•	Sta		31. Date filed (Month, Day, Year)	32 Regis	death (Item 23a) (Type, Itm CP8 f	selle)			,	
	Registr	ar	SEP 1 2 20	106	Alland St. S. S.	SUPPLIES TO SERVICE STATE OF THE SERVICE STATE OF T				

			1 - For State Registrar	State of Ma	ryland / De <i>C</i>	partment of H ertificate of L	ealth and M Death	Mental Hygi	ene 2006	2889
	Physici /Medio		Decedent's Name (First, Middle, Las	ROB!	ERT B. Y.	ATES		2. Date of Death Month Sept. 5.	Day Year	3. Time of Death  1:30 P M
	Examin									
	Funeral Director		5. Social Security Number 6. Social Security Number 212–26–6015	9x 7. Age	(In yrs. last birthd	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 18,	year) 9. Birth Cou 1930 Ker	place (State or Foreign intry) 1tucky
	iand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	B Mary	ctor	Maryland Anne Ar	undel			Glen Bur	nie		1 ☐ Yes 2 No
	h with th	i Director	10e. Street and Number 30 West Furn	ace Branch	Road	10f. Zip Code	21061	10	g. Citizen of What Cou USA	ntry?
980	n 72 hours after death with the Maryland *natural', or itema 23a or 28a-f ahow edical Examinat must be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 131 Yes 2 1 No If Yes, Give Year or Dates:		3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: W	
5-0	72	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(G	cedent's Usual Occupa	luring most of work	king 16	6b. Kind of Business/Ir	ndustry
2121	yene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	e. DO NOT use retired. Truck Drive			TEamsters	Union 557
land	ld be filed ental Hygi ked other ic avant, I	To Be C	17. Father's Name (First, Middle, Last) Paris	Reed Yat	es	I	18. Mother's Nam Eva Arms	e (First, Middle, Ma	aiden Sumame)	
, Maryland 21215-0036	ind 2 shou alth and M 27 is mar er traumati	-	19a. Informant's Name/Relationship (7	Type, Print) (Wif		ailing Address <i>(Street a</i> West Furnac				,
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other once		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Funers	)	Glen H	sposition (Name of rematory or other place aven Mem Pl 22, Name and Addres	9/8/	06 (		own, State e, Maryland
ă	Den Imperior		7-			McCully-Po 237 E. Pat				1225-1856
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list on office, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Doe to (or as a	c insequence of):	enter the mode of dying	<b>V</b>	or respiratory arres	it,	Approximate I terval Between In et and Death
68760,	tificate be executed g physicien and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c. Due o (or as a	nay 6 conseque ce of):	trleny	Misery			Gyear
P.O. Box	death cer e attendin id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
	iaw requires that the es been signed by th 2 should be detache	Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.								the cause of death?
al Records,	The ate h	Completed						24a. Was an autopsy performs	prior to co	opsy findings available ompletion of cause of
Vital	Physician: The this certificate he ral director, page	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpai	ient 3□ DOA Othe	· ·	h (Check only one)		
n of	ing Phys	lon: To	27. Marrier of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		of 28c. Injury Work		28d. Describe how	ce 6 Other (Speci injury occurred	<u>y)</u>
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Coul not be 4 Homicide d mined	28e. Place of Injury building, etc.	y · At home, farm, (Specify)	M 1 1 1 Street, factory, office	'es 2 □No	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
ш	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai Ce	29a. Certifier 1 ✓ Certifying Phy	/sician> o the best of iner: Pn/the basis of e	xamination and/or	eath occurred at the tim investigation, in my op	e, date and place, inion, death occur	and due to the cau	se(s) and manner as se and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of our lier	and manner state	ed.	29c. License	number	290	d. Date signed (Month,	Day, Year)
)	1/20		1 4 1004	100			0094		9/5/2	0006
İ	100		Ellipt Gorbay	completed cause of dea		er Print) Arv	bler	Denie, M	d, 2106/	
è	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	frails!	/			

		•	For State	State of	Marylan		artment of F				2006	28892	
		1. Decedent's Name (First, Middle, Last)  2. Date of Death									3. Time of Death		
	Physici		Anne Y. Yakaitis	3					SEPT	Day 10	Yeer Ze G	7:00 AM	
1	/Medic Examin		4a. Facility Name (If not institution,		nber)		4b. City, Town, or Location of Death				county of Oealt		
	CAGIIII	Ο.	Morningside Ass:	isted Liv	ing		На	anover		An	ne Aru	ndel	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin	th v. Year)	9. Birth	nplace (State or Foreign	
	Director		213-18-1972	1 □ M 2 🖾 F	86	Yrs.	thorning bays	110010	07/26/	1920	MI		
	pud *		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
	Aanyla sho	ъ		A 1 - 1								1 ☐ Yes 2K No	
	28a-	ect	MD Anne  10e. Street and Number	Arunde1	<u> </u>	len Bu	10f. Zip Code			10g. Citize	en of Whal Cou	untry?	
	3a or	Funeral Director	1467 Pleasantvi	lle Drive			21061			U.S	. A .		
	ms 2	Jera	11. Marital Slatus	12. Was Dece	dent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		4. Race - Amer		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, the Medical Examinar must be notilled at	þ	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☒ No  1 ☐ Yes 2 ☒ No  1 ☐ Yes Give  Year or Dates:				r Yes, specify Cub 1 ☐ Yes 2 🖾 No	Specify:	o Hican, etc.)	s	Black, White	hite	
ည	72 ho	Completed	15. Decedent' (Specify only highest	s Education		(Give	dent's Usual Occup	during most of wor	king	16b. Kind	d of Business/I	ndustry	
7	iffin	n g	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT use retire	d)		n .	1 .		
2	led w lygier her tl		1.2 17. Father's Name (First, Middle, L	nast		Bank	Teller	18. Mother's Nan	no (Eiret Middle		king		
and and	htai H	Be	Phillip Yanchuk	asi/					Gomola	, Maidell S	umame)		
Maryland	hould d Me mark matic	ှင	19a. Informant's Name/Relationsh	in (Type Print)		19h Mailir	nn Address (Street	and Number or Ru		er City or	Town State 7	in Code)	
Z	d 2 s th an th an t7 ls		Mr. William Yaka		on		-	Landing		-			
	tem 2 tem 2		20a. Method of Disposition	ittib / b	20b. P	lace of Dispo	sition (Name of matory or other pla		Date		ation - City or 1		
Ē	ages ent of nt: If I		1 ☑ Burial 2 ☑ Cremation 4 ☑ Donation 5 ☑ Other (Sp		State		*	ark 09/1	3/2006	Glen	Burni	e. MD	
Baltimore,	permit. Pages 1 and Department of Heali Importent: If Item 2 eny injury or other ODC®.		21. Signature of Full wall Stride		,010			ss of Facility Si					
m	Depared Important Importan		DINDUGO	14ll In	0134	1	Second A	Ave SW; G	len Bur	nie,	MD 2106	51	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that co	aused the death	n. Do not ent	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
ě.	Physician		Immediate Cause (Final disease or condition ADVANCED DECOMPANIE)										
	/Medical Examiner		resulting in death)		or as a conseq								
	Examine	_	Sequentially list conditions,	b	or as a coneeq	and the second							
	B A F	ine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09-10 (	menda otis								
	xecut and and	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):							
8760,	ficate be executed physicien and stransit is the burial-transit	dicai		4									
687	ficate p phy as the	edic		u.									
P.O. Box	The law requires that the death cerrific ate has been signed by the attending p page 2 should be detached for use as	by Physician/M	1 II we hirth 2 Fetal death 3 Ectonic pregnancy							3d. Date of delimental Month			
ص	that th	Y P	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?	
rds	n sign								1 🗆 '	Yes 2	No 3□Pro	obably 4 □Unknown	
Division of Vital Records,	ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should	Completed	autopsy pri performed? de								24b. Were autoprior to death?	re autopsy findings available r to completion of cause of th?	
ā	rtifica	BeC	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o	one)	Α	2410	
<b>&gt;</b>	nysic nis ce	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatier	nt 3□ DOA Ott	er: 4 🗆 Nursing H	lome 5 ☐ Resi	dence 6	Other (Spec	INLIVING	
0	ng Pt fter th		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	f 28c. Inju Wo	y at	28d. Describe	how injury	occurred	,	
Sio	tendi leath. tor: A the fu	cati	2 Accident investig 3 Suicide 6 Could n	ation				Yes 2 □No	2011	<u> </u>			
₹	or At	Certification:	4 Homicide determi	ned 200. Flace	of Injury - At no ng, etc. (Specif	ome, tarm, str y)	reet, factory, office		City or To	wn, State)	Number or Hu	ral Route Number,	
_	pitel	Ce	29a. Certifier 1 Certifying	g Physician: To the	hest of my kno	wledge deat	h occurred at the fi	me date and place	and due to the	cause(s) a	nd manner as	stated	
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: Atter this certifica completely filled in by the funeral director, I	edicai	(Check only 2   Medical E	xaminer: On the ba	asis of examina	tion and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and p	place, and due	to the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month	), Day, Year)	
	/		mil	wi)			1	57531		Sepl	- 11,	2006	
	5		30. Name and address of person of Mohar NCG		e of death (Item VECerc	23a) (Type,	Print) Lwy Su	it 204	mille	BUL	4,n	1) 21108	
	Sta	ite	31. Date filed (Month, Day, Year)	32. 9	egistrar's Signa	lure /	harle						
	Regist	rar	SEP 1 2	ZUUD JO	FREUN.	10. 10							

			For State Registrar	State of M	1aryland / D	epartmei Certifica	nt of Health te of Deat	and M h	ental Hyg	iene 2	006	28893
	Decedent's Name (First, Middle, Last)  Physician  Physician  The physician								2. Date of Dea Month		3. Time of Death	
		/Medical Arthur Bernard				Ambro			August	19	2006	8:45 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution  Charlotte Hall				, Town, or Location narlotte				y of Death Mary	t o
	Funeval		5. Social Security Number		поше ige (In yrs. last birti			or 24 Hrs.	8. Date of Birth			lace (State or Foreign
U	Funeral Director		579-40-1354	i <b>X</b> XM 2□F		rs. Months	Days Hours		(Month, Day July 21	Year)	Cour	ington, DC
	D .		Usual Residence of Decedent 10a, State 10b, Count		10c. City, Town	or Logation	<u> </u>					0d. Inside City Limits
	Aaryia Fahor	ō		Arundel	Gambri							1 ☐ Yes 2X No
	28a-	rect	10e. Street and Number		00		p Code	<del>-</del> -	1	0g. Citizen of	What Cour	ntry?
	h with	D Is	907 Winterhave	en Drive			21054				USA	,
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow than "natural", or Items 12a notilliad at	by Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	13. Was Dece	dent of Hispanic C scify Cuban, Mexic	origin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ	
36	rs afte	y Fu	1XXVever Married 2 Ma 3 Widowed 4 Divorce	IT Yes Give	1951–53	1 🗆 Yes					y: Whi	
21215-0036	2 hou	ted t	15. Decede	ent's Education		Decedent's Usi	al Occupation			16b. Kind of B	Business/Inc	dustry
215	thin 7:	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1-4or	5+)	(Give kind of w life. DO NOT i	ork done during mo use retired)	ost of workir	ng			,
2	ygien yerth t, the	Con	12			gineer						intenance
Maryland	I be fill he dots	Be	17. Father's Name (First, Middle Arthur Ambros						(First, Middle, I Deaver		me)	
2	should nd Me mark matic	ဥ	19a. Informant's Name/Relation		19b.	Mailing Addres	s (Street and Num				State Zin	Code
Ma	nd 2 salth ar 27 is 27 is r trau		Alice Horton				chaven Dr					
ore,	of Heg		20a. Method of Disposition	5 DD		Disposition (Na		D	ate	20c. Location	- City or To	wn, State
Ē	Page ment ant: If ury or		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		9	•	cans Cem	8/28/	2006	Crowns	ville	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 ahow ampropriant if Itams are a second in the confine and the collisist at once.		21. Signature of Funeral Servin	enicensee		22. Name a Hard 851	od Address of Facties ty Fur Annapoli	neral Is Roa	Home, P	.A. rills,	MD 2	1054
п			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause st only one cause on each	ed the death. Do n line.	ot enter the mo	de of dying, such a	as cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Meta	estatic	Ade	uoca	vci	пота	of E	sopl	Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or a	s a consequence o					,		-0
	1;	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence o	f):	honi	C	lisea	se		
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	1. Dia	betes	Me	ellitu	S				
Ö,	ate be executed hysicien and the burial-transit	Ex	resulting in death) Last	Due to (or a	s a consequence o							
8760,	icate be executed physicien and s the burial-transit	dlcal		d. My	portug	1010	15m	-				
9 X	eath certifii ettending I I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-	e of pregnancy					22d Da	ate of delive	
Вох	death cer e ettendin d for use	lclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetaf death at time of death	3 □Ectopic p 5 □ Other (s						Day Year
<u>Р</u> .	at the by the tache	hys	9 □ Unknown	9□ Unknown								
S, F	Attanding Physician: The law requires that the death certific robath. crost After this certificate has been signed by the ettending p crost After this certificate bas been signed by the funeral director, page 2 should be detached for use as	Ď	Part II. Other significant condit	tions contributing to death	but not resulting in	the underlying	cause given in Par	t I.				e cause of death?
ord	w requir been si should	eted	rug per ux	orcerna					1   Ye	s 2 No	3 Prob	ably 4 Onknown
žec	has the	Completed	Kenal	Insuf	ficies	scy			24a. Was a autops perform	y	Were autoprior to condeath?	psy findings available inpletion of cause of
a	Physician: The lav this certificate has al director, page 2	င္ပ	25. Was case referred to medic.	<b>7</b>	<u> </u>				1 ☐ Yes 2	2 No		2 No
<u>=</u>	ysicia s cart direct	To Be	examiner?	Hospital:	ient 2 ER/Out	natient 3□ D	-1-		Check only on		or /Specifi	4)
<u>0</u>	ng Ph ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Oate of Inj			28c. Injury at Work?		8d. Describe ho			"
Sio	uttendir death. ctor: Al y the fu	catle		tigation		М	1   Yes 2	□No				
Division of Vital Records,	l or At after d Direct	Certification:	4 Homicide deter	mined 289. Place of Ir	njury - At home, far atc. <i>(Specify)</i>	m, street, factor	y, office	2	8f. Location (St. City or Town	reet and Numi i, State)	ber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Cartifyi (Check only 2 Medica	ing Physician: To the bes	t of my knowledge,	death occurred	at the time, date a	and place, a	nd due to the ca	use(s) and m	anner as st	ated.
	To the Howithin 24 To the Fu	Medical	One)	I Examiner: On the basis and manner s	tated.							
	o vil	~	29b. Signature and title of certifi	el_	1 4.0		c. License number	_	1	9d. Date signe		
,			30. Name and address of perso	/Stammer	death (Itam 22a)	)	04509	d		8/19	100	0
	5.1		III Has his	who completed cause of Roacl	SUIT	ypa, Print)	205	Pin	COF.	odvic	cle	20678
	Sta		31. Date filed (Month, Pay, Year AUG 25		trar's Signature	1		1. 7.17.6			1	~~~~
	Registr	ar	HUU & D	2000	w so to							

			1 - For State Registrar	tate of Mar	yland / Depa <i>Cei</i>	artment rtificate	of He	ealth and l Death	Mental Hyg ғ	giene Reg. No.	006	28894
	Physici /Medic		Decedent's Name (First, Middle, Last)     BJORN ANDERSEN					2. Date of Dea Month August 2		3. Time of Death  11:50P M		
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, To Berli		ocation of Deat	n		unty of Death ester	
	Funeral Director		5. Social Security Number 6. Sex 12. M		In yrs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 31,	, Year)	9. Birthi Coul Denm	-
1275-0036 within 72 hours after death with the Maryland	h the Maryland r 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Worcester		Oc. City, Town or Lo Berlin	cation						10d. Inside City Limits 1 ☐ Yes 21 No
	ath with the 23s or 28s	I Director	10e. Street and Number 6910 Hall Dr.		101. Zip Code 21811					10g. Citizen of What Country? U • S • A •		
350	us after deati il', or Iteme 2 xaminer ma	by Funeral	11. Marital Status 12. 1	Vas Decedent Eve Armed Forces? ☐ Yes 2X☐ No f Yes, Give Year or Dates:	l:	Nas Deceder	nt of His y Cuban	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No-	14.1	Race - Americ Black, White, ecify: Whi	etc.
9500-6121	d within 72 hours after des piene. Ir than "netural", or Iteme Ite Medical Examiliar m	Completed	15. Decedent's Education (Specify only highest grade co	n mpleted) College (1-4or 5+)	(Give	DO NOT use	done du retired)	iring most of wor	king		f Business/In ct Man	dustry ufacturing
Maryland 2	Hygi other	To Be Co	17. Father's Name (First, Middle, Last)  Knud Andersen  General Manager  18. Mother's Name (First, Middle, Maiden Sumame)  Kate Pedersen									
	and 2 sho ealth and t n 27 is ma		19a Informant's Name/Relationship (Type, Sandra H. Andersen	6910 H	Hall D	r.	Berlin,	MD 21	ber, City or Town, State, Zip Code)			
gaitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic a once.		20a. Method of Disposition 1 □ Burial ② □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	Validiti State	20b. Place of Dispos cemetery, crem Sunset Men				/06	20c. Location Berli	on - City or To	own, State 21811
Rail	Departit Departiment Importany in			lage	T1 3.0.1	3 Will:	bage iam	Funera St. Be	rlin. MD	218	311	
	Physician /Medical Examiner		23a. Part1. Enter of ofisease, or complication shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death)		e death. Do not ente	er the mode of	of dying,	such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events c.	ons <del>a</del> quence of).								
38/60,	icate be executed physicien and s the burial-transit	dlcai	resulting in death) Last	onsequence of):								
O. BOX C	w requires that the death certif been signed by the attending should be detached for use a	Physician/Me	in the past 12 months?		death 3 ☐ Ectopic pregnancy					23d. Date of delivery Month Day Year		
oras, r	requires that the een signed by th hould be detache	þ	Plant II. Other significant continuous contributing to death out not resulting in the underlying cause given in Part I.									ne cause of death?
Lec	The lar ate has page 2	Completed							24a. Was a autops perfore 1 🗆 Yes	med? 2 <b>S</b> ANo	b. Were auto prior to co- death? 1 \sum Yes	psy findings available mpletion of cause of 2 No
	> 07 TO	To Be	25. Was case referred to medical examiner? 1 Yes 2 Solo	1 L Inpatient	2 ER/Outpatient		Other	4 ☐ Nursing H	th Check only or ome 5 Reside	ence 6 🗆 0	Other (Specif	y)
	ng ther	Certification:	1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day You Be. Place of Injury building, etc. (S	ear) Injury  - At home, farm, stre	28b. Time of Injury at Work? 28d. Describe Work? 1 Yes 2 No				e how injury occurred  (Street and Number or Rural Route Number, own, State)		
ב	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the th	edical Ce	29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	n: To the best of n On the basis of ex and manner stated	amination and/or inv	occurred at restigation, in	the time	, date and place nion, death occu	, and due to the c rred at the time, d	ause(s) and ate and plac	manner as si ce, and due to	tated o the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier	/		1	icense				ned (Month,	
7	(8)		30. Name and address of person who complete the second of	TIN, M.	h (Item 23a) (Type, F	Print)	C.	1011 5	51., 5	c 135	10-7,	200C
ÿ	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2006	32. egistrar's	Signature	oute						

DHMH 17 Rev 1/2001

			1 - State of Maryland / Department of Health and M Certificate of Death		giene Reg. No.	006	28895
	Physicia		1. Decedent's Name (First, Middle, Last) Zelma Lucille Anderson	2. Date of Dea	Day	Year 2006	3. Time of Death
1	/Medic Examin	-20	4a. Facility Name (If not institution, give street and number)  CARPOLL COUNTY HOSPILAI  Westminster		4c. Cou	rrol/	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day June 8	1932	9. Birthpl Coun	ace (State or Foreign try)
	Maryland -f ehow	tor	10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
	h with the 23a or 28a at be noti	ai Direc	10e. Street and Number 4729 Old Mill Bottom Rel. 21779			of What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 te marked other than "naturel; or items 23a or 28a-f ehow ery injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Sive 1 Yes, Give 1 Yes 2 No 1 Yes 2	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, e poify: BLA	etc.
21215-0036	hin 72 hours s. sn "naturel Medical Ex	Completed t	3   Widowed 4   Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4or 5+)  College (1-4or 5+)	ing	16b. Kind of	f Business/Inc	
	be filed wit ital Hyglene id other tha	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	-7	SCHO Maiden Sum	oc B	OAKS
Maryland	and Men e marke sumatic	2	19a. Informant's Nam - elationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Numbe	r, City or Tov		
	of Health of Health if item 27 or other tr		cemetery, crematory or other place)	Date	20c. Location	n - City or To	wn, State
Baltimore,	permit. Pag Department Important: eny injury c		21. Signature of Funerat Service Licensee  22. Name and Address of Facility	O WES	r Sour	7+ 55	
	adge d		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or head failure. List only one cause on each line.			DEACH	Approximate Interval Between
	Physician /Medical		trimediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Onset and Death
***	Examiner	Jer	Sequentially list conditions, if any, Ladming to immediate cause. Enter Underlying				
, 0,	ate be executed hysicien and the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):			-	
68760,	rtificate b ng physic as the b	Aedical	d.				
.O. Box	he death certific the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   1 □ Live birth 2 □ Fetal death   3 □ Ectopic pregnancy   5 □ Other (specify)   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision   1 □ Vision			Date of delive Month	ry Day Year
σ	requires that the de een signed by the a hould be detached (	þ	Farth. Other digital contained contributing to death out not resulting in the underlying cause given in Part i.	23e. Did to			e cause of death?
of Vital Records	e law has b	Completed		24a. Was autop	sy	b. Were autor prior to con death? 1 \( \text{Yes}	osy findings available inpletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Check only o	ne)		
	ding h. After fune	tion: To	1 Minpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	me 5 Resid 28d. Describe h			')
Division	2 Strice	Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		mber or Rura	Route Number,
	Hospital     124 hours a     Funeral D     letely filled i	edical		and due to the ded at the time, d	ause(s) and date and place	manner as sta	ated. the cause(s)
)	To the I within 2 To the Complet	Me	29b. Signature and title of certifier  29c. License number		29d. Date sig	ned (Month, )	Day, Year)
-	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			001	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 3 0 2006  32. egistrar's Signature			-	

AMEND 20 lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 20c State of Maryland / Department of Health and Mental Hygiene 1- State WCHD/SH 9/5/2006 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician AUGU5T KICHARD 30 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY Baltimore THE JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Hours Min. Yrs. Director 94-38-7601 59 PA Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County IT is marked other than "netural", or Items 23s or 28s-1 ehow treumstic event, the Medical Exampler must be notified at 1 ☐ Yes 2 ☑ No Director Juniata Millerstown 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code RR2 Box 484 17062 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) i other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Laundry Worker State School permit. Pages 1 and 2 should be file Deputrment of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumstic event 9DRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Κ. Auker Mary Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene I. Auker RR2 Box 484 Millerstown. 17062 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Millerstown, PA 20a. Method of Disposition St.PetersU.C.C.Cem 9/3/06 22. Name and Address of Facility George P. Garman Funeral Home 21. Signature of Funeral Service Licensee M. MO1035 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9366RT.35 Mt. Pleasant Mills, 17853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLLAPSE JARDIOVASCULAR Physician hour /Medical Due to (or as a consequence of) Examiner UPRAVENTRICULAR ARRHUTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificete 2 NO 1 ☐ Yes To the Funeral Diractor; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1/ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medicai Certification; 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24s Cartifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santosh 600 North Wolfe Oonmen Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 1 2006 Registrar

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or Health and fitem 27 is m r other traum		19a. Informant's Name/Relationship (7.  Terri Butler/Dau  20a. Method of Disposition 1□Burial 2 (季Cremation 3□	ghter 20b.	P. O	. Box 2	182 Ad	dison, TX	7500		
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State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** VIRGINIA ANN BURDETTE awg 27 2006 ar 9:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Oeath 4b. City. Town, or Location of Death Examiner 19730 MOUTH OF MONOCACY RD. DICKERSON MONTGOMERY Months Days Hours Min. 8. Date of Birth MAR 54. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 Ø F 61 Yrs. 219-42-3503 Director MD Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "naturel", or items 23s or 28s-f ehow traumatic event, the Modical Examinat must be notified at MONTGOMERY MD DICKERSON 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20842 19730 MOUTH OF MONOCACY RD. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MONTG. CO. SHERIFF\$ al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY DEPARTMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental h n and Mental RAYMOND LEIGH FENNEMAN DOROTHY BARBOUR ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
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VA 23456 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Heelth an LISA DUNN-WRIGHT / DAUGHTER 1940 CLIFTON BRIDGE DR., Itam 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/06 DARNESTOWN CEMET. DARNESTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) YEARS METASTATIC NON SMALL CELL LUNG CA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? certificate 2 A No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42452 AUG 28, 2006 who defayon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 18111 PRINCE PHILLIP DR., OLNEY, CHITRA RAJAGOPAL, MD31. Date filed (Month, Day, Year) 32. Poistrar's Signature State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28900 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 21, 2006 **Physician** George W.H. Beal 6:22 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15 Guthrie Rd. Grantsville Garrett 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 10,1921 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 1**X** M 2 □ F 174-16-1821 85 Pennsylvania Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits od other than "natural", or Items 23a or 28a-f show event, Ite Mudical Examiner must be notified at 1 Yes 2 No Director Somerset PA Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15501 USA 134 Evergreen Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married □Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Yes. Give Specify: ģ Specify: 3 X Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Farming permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 9DEs. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Simon Beal Margaret Wyand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Evergreen Rd., Somerset, PA Lowell W. Beal/Son 15501 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) Berlin I.O.O.F. Cem. August 25,2006 Berlin, PA 21. Signature of Funeral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. lumai P.O. Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCVD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ached Division of Vital Records, P.O. the 9 Unknown 9 Unknown be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes or Attending Physician: 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1end's P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Residence Certification; 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the t 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 Janus H 26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller, D.O., 69 Wolf Acres Rd., Oakland, MD 2006 32. Registrar's Signature 31. Date filed (Month, Da State Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			giene 199. No. 2006	28901
Šą.	Physici		Decedent's Name (First, Middle     Samue1 Jan	_	an.			2. Date of Dea Month Septemb	Day Year	3. Time of Death 10:44 a M
	/Medio		Samuel Jan  4a. Facility Name (If not institution		<u> </u>	4b. City, Town, o	or Location of Death	Берсени	4c. County of Death	10:44 4
			Garrett County	Memorial H	ospital	Oaklan	d		Garrett	
A	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth	place (State or Foreign ntry)
*	Director		214-42-0328	TAX M ZCIP	66 Yrs.			July 26		yland
pue	<b>*</b> ≡		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
N S	9 2	ţō	MD Garr	ett	0akland				1	1 ☐ Yes 2 🙀 No
đ đ	1288	Funeral Director	10e. Street and Number		Jakiana	10f. Zip Code		1	log. Citizen of What Cou	ntry?
th W	23a	aiD	67 Bethel Road			215	50		United Sta	ates
r dea	eme ETJ	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	o,		1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, Give	No	1 ☐ Yes 2 X No			Specify:	• •
21215-0036 d within 72 hours after death with the Maryland	tura E	Completed by	15. Deceden	Year or Dates:	VIC CHain	dent's Usual Occup	pation		16b. Kind of Business/Ir	nite
215	Medic	piet	(Specify only highes Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retired	during most of work	ring		
2121 gwilling	I Hygiene. other than '	E O	12	College (1-401		ıck Drive	r		Transporta	ation
	al Hy I oth	Be (	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
aryla should	nd Mental marked o	2		man			Margar		Glotfe	
-	raum		19a. Informant's Name/Relations						r, City or Town, State, Zi	o Code)
<b>e</b> , -	I Health and Montal Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28e-f ehow other traumatic avent, II's Modical Exerciper result be notified at		Mrs. Norma Boy 20a. Method of Disposition	man, Wite	20b. Place of Dispo		ad, Oakla		21550 20c. Location - City or T	own State
Baltimore,	Department of Heal Importent: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation		cemetery, cre	matory or other place	ce)			
	artme orten injury		4 ☐ Donation 5 ☐ Other (S		the state of the s	VILLE Cem  2. Name and Addre	etery 9/5		McHenry, N	
ä	Depa Impo any ii		WARE IN	Mairen			Du		ırst Funeral akland, MD	
	V Augi		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that dause	the death. Do not en					Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	Only one cause on each	C ( D C) AAA	of the	PANC	DEAR		Onset and Death
100	/Medical		resulting in death)	a. Due to (or as	a consequence of):	of the	- MAG	KC/D		13 years
E	xaminer		Sequentially list conditions.	b						
D D	sit s	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
Kecute	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	hysician and the burial-transit	cal E								
<b>687</b>	phys as the			d.					. 7	
Box 66	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deliv	ery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown	_	Other (specify)	<i>y</i>		Month	Day Year
0. 5	f by the	Phy	9 Unknown							
	signed by the a	þ	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	ınderlying cause gıv	en in Part I.		bacco use contribute to les 2 No 3 ☐ Pro	he cause of death?
Records,	been sig	Completed						1 🗆 Yo		•
Rec The law	2 2	I d m						24a. Was a autops perform	sy prior to co	opsy findings available empletion of cause of
		မ င	05 Wes					1 ☐ Yes	2 No 1 Yes	2 No
of Vital	is certific director,	00	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat		ence 6 □Other (Speci	<b>6.</b> 1
9	er this	n: To	27. Manner of Death	28a. Date of Inju	ry 28b. Time o				ow injury occurred	ry)
Vision	death. Xor: After	atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		y Year) Injury		Yes 2 □No			
Division of	efter death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad   286. Place of In	ury - At home, farm, st	reet, factory, office		28f. Location (SI City or Town	treet and Number or Run n. State)	al Route Number,
	rai Di								·	
Hosping	within 24 hours effer death.  To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 12 Certifyin (Check only 2 Medical	g Physician: To the best Examiner: On the basis o	f examination and/or in	h occurred at the tire	me, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner as s late and place, and due t	stated. o the cause(s)
the	thin of the omple	Med	29b. Signature and title of certifier	and manner st	ated.	29c. Licens			29d. Date signed (Month,	
ř	60		1.16	A had	MA		2720	5	9/7/20	0 6
+	-IVA		30. Name and address of person	who completed cause of	death (Item 23a) (Type		1 20		1/4/4	,0,0
			KARL E	Sutwai	M 3/1	N. 4	m 5+	OAK	LAND M.	$\mathcal{Q}$
	Sta		31. Date filed (Month, Day, Year)	5 2006 32. Registr	ar's Signature	<i>d</i>			)	
	Registr	ar	<u> </u>	2000	120 A A	100				

			For State Registrar	State of	Maryland /	Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	and M	lental F	lygie Reg.		6 28902
	Physici		1. Decedent's Name (First, Middle Mary	, Last)	Bashar	n					2. Date of Month		Day Year	3. Time of Death 1900 p <sup>M</sup>
, see	/Medic Examin Funeral Director		4a. Facility Name (If not institution, Sunbridge of 5. Social Security Number 193-16-2190	Elkton			4b. City, T	E.	Location o 1 k t o If Under 2 Hours	of Death	8. Date of		4c. County of De	ath i 1 inthplace (State or Foreign Country)
	9	tor	Usual Residence of Decedent  10a. State 10b. County	cil	10c. City, To						03/2		920 Mt	• Bethal N  10d. Inside City Limits  1 □XYes 2 □ No
	s 1 and 2 should be filed within 72 hours after deeth with the Marylend f Heelth end Mentel Hyglene. Item 27 is marked othar then "naturel", or itame 23e or 28a-1 ehow othar treumatic event, the Madical Examinat must be notified at	eral Director	10e. Street and Number 210 North St	reet	lent Ever in U.S.		10f. Zip (		2192		acify Vac or		Citizen of What C	
9000	hours after d ture!, or itan al Examiner	d by Funeral	1 ☐ Never Married 2 ☐ Marri 3 🔯 Widowed 4 ☐ Divorced	Armed Forced 1 Tes 2 If Yes, Give Year or Date	ces? 2 🖄 No les:	1	∣□Yes 2	<b>X</b> No	Specify:	, Puerto	ecify Yes or Rican, etc.)		Black, Wh	white etc.
Maryland 21215-0036	e filed within 72 el Hyglene. I othar then "nai vent, the Medie	Completed	15. Decedent' (Specify only highes  Elementary/Secondary (0-12)  Unknown  17. Father's Name (First, Middle, I	grade completed) College (1-		(Give	lent's Usual kind of work DO NOT use La	done de retired)	uring most				Plasten Sumame)	
aryland	2 should be for and Mentel His marked of reumatic ever	To Be	Fred B. Till  19a. Informant's Name/Relationsh	ou	19	9b. Mailin	g Address (		El.	izal	oeth	Mor	rison ty or Town, State,	Zip Code)
aitimore, M	Peges 1 and 2 nent of Heelth int: if item 27 i		Carolyn Gall  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sc	3 □Removal from S	20b. Place ceme	of Dispos tery, cren	Bunn sition (Naminatory or oth V Gi	e of her place	1		ad, B Date /28/0	20c	or, PA Location - City o	r Town, State
Baiti	permit, Peges Depertment of important: if if eny injury or o		21. Signature of Fineral Service L	Int	C0442	22 E e 20	Name and eson 53 Pi	Address Fur ulas	nera ski	y l Ho Hwy	ome o	f N ark	ewark , DE	Approximate
	/Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.  Due to (a	r as a consequent	rolic	they.		Dr.			arrest,		Interval Between Onset and Death Conknown
8760, I	icate be executed physician end s the buriel-trenalt	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequenc									
P.O. Box 68	The lew requires that the death certifics tie has been signed by the ettending ph age 2 should be deteched for use es to	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live bir	ome of pregnancy th 2 ☐ Fetal dea nt at ti <i>m</i> e of death vn		Ectopic pre					-	23d. Date of de Month	elivery Day Year
ords, P.	w requires that is been signed by should be dete	ted by Ph	Part II. Other significant condition	ns contributing to dea	th but not resulting	j in the un	derlying ca	use give	n in Part I.					to the cause of death? Probably 4 Munknown
al Reco	n: The lew r licate has be or, page 2 sh	Completed	25. Was case referred to medical						00 5		1 ☐ Yes	topsy rformed 2 2	🚰   death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The i within 24 hours after deeth.  Within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification; To Be	examiner?  1 Yes 2 Ao  27. Manner of Death  1 Natural 5 Pending  2 Accident investig  3 Suicide 6 Could n	ation at he	Injury 28b	. Time of Injury	28 M	c. Injury Work' 1  Y	r: 4 Nur	sing Hor	28d. Describ	sidence e how ir	6 ☐Other (Sp.	
DIV	spital or Al nours aftar neral Direc filled in by		4 Homicide determine 29a. Certifier 1 Certifying	Physician: To the b	f Injury - At home, g, etc. (Specify) est of my knowled	lge, death	occurred a	t the time	e, date and	place, a	City or 1	own, St	ate)	Rural Route Number,
)	To the Hospital within 24 hours a To the Funeral i completely filled	Medical	(Check only 2   Medical E	xaminer: On the bas and manne	is of examination a r stated.	and/or inv	estigation, i	n my opi	nion, deat	h occurr	ed at the tim	e, date a	and place, and du	e to the cause(s)
	4		30. Name and address of person w  S.S. Sadde.  31. Date filed (Month, Day, Year)  AUU 2 9 200	ho completed cause	of death (Item 23a	Lype, I	F Su	ile	3B	4	sek?	n	10219	72/
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUU 2 9 200	6 <b>Mark</b>	gistrar's Signature	borte								

			1 - For State Registrar	State of Mary	-	artment of		d Mental Hy	ygiene	6 28903
	Physic /Medi	cal	Decedent's Name (First, Middle, Last     EVA M. Bva     Aa. Facility Name (If not institution, give	dley		4h City Toye	n, or Location of D	2. Date of D Month Aug		
	Examir Funeral Director	ner	Mercy Medica 5. Social Security Number 6. Se	e Center	yrs. last birthday) 96 Yrs.		hm ove	Hrs. 8. Date of B	nla	Beath  Birthplace (State or Foreign Country)  Maryland
		Director	Usual Residence of Decedent  10a. State 10b. County  Maryland n/a	100	c. City, Town or Lo			2000		10d. Inside City Limits 1 🕱 Yes 2 □ No
0036	within 72 hours after death with the Maryland ane then "natural", or itema 23a or 28a-f ehow a Madical Examinat must be notilised at	by Funeral	100. Street and Number  1101 St. Paul Stre  11. Marital Status  1 ★ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 □ Yes 2 💢	21202 of Hispanic Origin Luban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	Specify:	American Indian, White, etc. White
Maryland 21215-0036	be filed ntal Hygis of other event,	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei Stered	ne during most of tired) NWSE		Health C  Maiden Sumame)	,
Baltimore, Maryla	permit. Pages 1 and 2 should the Department of Health and Ment Importent: If item 27 is marked eny Injury or other traumatic space.	То	Charles H. Bradle  19a. Informant's Name/Relationship (7)  Ann Taylor/Niece  20a. Method of Disposition  1 Burial 2 Cremation 3 Dt  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	1630 Db. Place of Dispo cemetery, cres Pleasant	Theodor esition (Name of natory or other p Grove ( 2. Name and Ad	eet and Number of  Road,  place)  Cemetery  dress of Facility	Rising Su <sub>Date</sub> 8-30-200	per, City or Town, Sta Ln. MD 219 20c. Location - Cit Peach Bo P.A. MD 2	11 y or Town, State
8760,	death certificate be executed  Wedical  Examiner  and for use as the burial-itansit	dical Examiner	23a. Partl. Enter the disease, or comp shock, or heart failure. List only limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, framediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	er the mode of d	dying, such as car	diac or respiratory a	arrest,	Approximate Interval Between Onset and Death
P.O. Box 68	death certif e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of print of the second o	Fetaf death 3□	]Ectopic pregna ] Other (specify)			23d. Date o Month	delivery Day Year
	requires been sign should be	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.	_ 10	Yes 2 No 3[	te to the cause of death?  Probably 4 Dunknown
Division of Vital Records,	The farate has	: To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No	dospital: 1 A patient 28a. Date of Injury	2 C ER/Outpatien	1 30 DON	Other: 4 🗆 Nursin	1 ☐ Yes Death (Check only of g Home 5 ☐ Resi	psy prior deat 2 No 1	Yes 2□ No
Division	To the Hospital or Attending Physician: within 24 hours after dealy within 24 hours after dealy to the Funeral Director. After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day Yea 28e. Place of Injury - building, etc. (Sp	r) Injury At home, farm, str		☐Yes 2☐No		Street and Number o	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C	Medical (	29a. Certifier (Check only one)  1 Certifying Physical Exemination (Check only one)  1 Certifying Physical Exemination (Check only one)  29b. Signature and title of certifier	sician: To the best of my ner: On the basis of exar and manner stated.	nination and/or inv	estigation, in m	y opinion, death or ense number	ccurred at the time,	date and place, and 29d. Date signed (N	due to the cause(s)
	5 Sta Registr	-	30. Name and address of person who con N1' Chelle Gvee 31. Date filed (Month, Day, Year)  AUG 2 9 2006	mpleted cause of death  1 0 2 0 F  32. Registrar's S	(Item 23a) (Type,	Print) Wenu	· Ay+s	II Ball	more	42006 Mn 21201

			1 - For State Registrar	State of Mai		artment of F		Mental Hygi	ene g. No. 20	106	289	)01
	Physici /Medio		Decedent's Name (First, Middle, Last,     KATHLEEN	BO	WERS			2. Date of Death August	21, 2	2006	3. Time of De 8:00P	
	Examir		4a. Facility Name (If not institution, give 17004 Freedom	Way			kville		4c. County	gome	-2	
	Funeral Director		5. Social Security Number 6. Sec. 212-64-8043	x 7. Age	(In yrs. last birthday, 50 Yrs.	Months Days	If Under 24 Hr Hours Mir		1°9′55	9. Birthpl Count Maj	ace (State or Fo try) cyland	oreign
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow fa Meulcal Exarvitier naat be notified at	Director	10a. State 10b. County MD Montg		10c. City, Town or L	kville		10	g. Citizen of W		od. Inside City L 1 ☐ Xes 2 [	
	Jeath with	Funeral Di	17004 Freedom	12. Was Decedent Ev	ver in U.S. 13.		20853		U.S	A.		
9800	ours after o	d by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		k, White, e	etc.	
Maryland 21215-0036	within 72 h iene. rthen "natu	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w d)	orking 1	6b. Kind of Bu	siness/Ind	ustry	
yland ?	2 should be filed and Mental Hygi Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Ralph Henness				18. Mother's Na	ame (First, Middle, M Leanor Z	aiden Sumame	э)		
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Iteme 23a or 28a-f ehow important: If Itam 27 is marked other then "natural", or Iteme 23a or 28a-f ehow injury or other traumatic event, the Medical Exactination and page.		19a. Informant's Name/Relationship (Ty Kenneth D. Bow) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signat F of Funeral Service License	ers- Husk	oand 17 20b. Place of Dispo cemetery, cre Gatte o	004 Free osition (Name of matory or other place f Heave) 2. Name and Addre	edom Wa	Rural Route Number, Pay Rocky: Date 2 25/06 Snowden I Jton St I	lle, Oc. Location - O Silve unera	MD 2 City or Tow r Sp	20853 wn, State oring, ome, PI	A
8/60,	Cate be executed  Medical  Examiner  the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or compositions, or heart failude. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	DID SYND consequence of):		g, such as cardia	ac or respiratory arres	st,	i	Approximate Interval Betwee Onset and Deat	
O. Box 6	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ] Other <i>(specify)</i>			23d. Date Mon	of deliver	y Day Year	г
2	w requires that been signed by should be deta	Ď	Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.				cause of death	
Vital Records,		Completed						24a. Was an autopsy performe	ed? de	for to come	sy findings avai pletion of cause ⊇⊡ <b>X</b> o	lable e of
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	lospital:	2 🗋 ER/Outpatier	nt 3□ DOA Oth		eath Check only one Home 5 Residen		e (Consta		-
	Attending Phir death.  ector: After this by the funeral		27. Manner of Death  1X Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Y		f 28c. Injun Worl	/ at ⟨? Yes 2 □ No	28d. Describe how				
DIVISION	P Sign	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.				28f. Location (Stre City or Town,	State)			
	24 h 24 h Fur etely	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of ones. On the basis of example and manner state.	kami∩ation and/or in	h occurred at the time vestigation, in my of	ne, date and plac pinion, death occ	e, and due to the cau curred at the time, dat	se(s) and man e and place, ar	ner as sta nd due to t	ted. he cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	01. 1	M	29c. License			I. Date signed			
1	20		30. Name and address of person who co	mplet ear	th (Item 23a) (Type,	1	0055522		Augus	t 22	, 2006	;
			Robert H. Gera	ard, MD 1	500 For	est Gler	Road,	Silver	Spring	g,MD	20910	)
	Sta Registr		31. Date filed (Month, Day, Year)  AliG 2 8 2	32. Redistrar's		barker						

06-06211 Dorge Roraldo Barrera - Barrera
Please Ty
UNK UNK State of Maryland

00211		Please Type or Print in Black Indelible ink	
K UNK		State of Maryland / Department of Health and Mental Hygiene	
	1- For State	Certificate of Death	_

Physici		1- For State Registrar		Certi	ficate of	Death		R	eg. No.	nne soe
	ian/	Decedent's Name (First, Michael Control of the						2. Date of Dea	th C	36 ime of Geeling
dical Exami	iner		Ronaldo B		· · · · · · · · · · · · · · · · · · ·	- Oh. 7-		Month August 19		1/15 nrs
		4a. Facility Name (if not institu Route 15 at Route 4	-			b. City, Town, or L Point of Roc		eath	4c. County Frederic	
Funeral Director		5. Social Security Number  None	6 Sex	7. Age (In yrs. last 25	- ,	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8 Date of Bir Min. 01-25	,	y) 9 Birthplace (State or Foreign Guatemala Country)
	1	Usual Residence of Decedent		ł			<u> </u>			
v any		10a. State 10b. Count	ty	10c. City, To	own or Location	on				10d Inside City Limi
Maryland 28a-f show any 1 at once.	5		irfax	Cent	revill	.e				1 Yes 2 X
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiens the manural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 14817 Slethwic	ck Place			10f. Zip Code 2012	0	1	Og Citizen of Wi Guatema	,
with ms 23 be no	eral	11. Marital Status	A	cedent Ever in U.S.				( Specify Yes or No		e - American Indian, Black,
fter death I", or ite	y Funeral		Married Armed F  1 Yes Divorced If Yes, Give Ye	2 X No		es, specify Cuban, Yes 2 No		alan spanie		e, etc. Cauçasian
ours al atural camin	d b	15. Decedent's Education (S	or Dates: pecify only highest gra	ide completed) 1	6a Decedent	's Usual Occupation	on (Give kind	of work done	16b. Kind of Bu	usiness/Industry
672 hg	Completed	Elementary/Secondary (0-1:	2) College (	1-4 or 5+)	during mo	st of working life. I	DO NOT use	retired)		
21215-0036 Juld be filed within 72 Mental Hygiene marked other than ' c event, the Medical	티	12			F	oreman				ruction
15-C		17. Father's Name (First, Midd				11		ame (First, Middle, I		9)
TT Z Id be Menta narke	To Be	Jorge Ronaldo  19a. Informant's Name/Relatio			10h Mailing	Address (Street		dina Rono		vn, State, Zip Code)
Baltimore, MD 21215-0 permit Pages I and 2 should be filed w Department of Health and Mental Hygis Important: I fitem 27 is marked othe injury or other traumatic event, the N	P	Eric Barrera						, Manassa		
and 2 and 2 Health item 2 traus		20a. Method of Disposition			ace of Disposi	tion (Name of cem	etery,	Date	20c. Location	- City or Town, State
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		1 X Burial 2 Cremati		TOTAL OTALC	ematory or oth	<sub>er place)</sub> sso Cemet	ory	08-27-06	Progra	esso,Guatemala
nit Partmen		4 Donation 5 Other 21. Signature of Funeral Service		1 1		ame and Address		00-27-00	Trogre	esso, Guatemaia
Dep ninje		many	Holden				,	Manassas	s, Va. 2	20109
hysician		23a Part I Enter the dease,	or complications that	caused the death. D			<u> </u>			art Approximate Interv
/Medical	1	failure. List only ne cau Immediate Cause (Final disea		iuries						Between Onset an Death
Examiner		or condition resulting in death		a consequence of):						
	L	Sequentially list conditions,	b							
	ine	if any, leading to immediate cause. Enter Underlying Caus	se	a consequence of):						
	1 ≻ 1	(Disease or injury that initiated		a consequence of):						
=	xar	events resulting in death) Las	t Due to (or as							The state of the s
ecuted and transit	al Examiner		d							
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be exe 42 hours after death. Funeral Director: After this certificate has been signed by the attending physician relay filled in by the funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	UNPENDED  IF FEMALE: 23b Was decedent pregnant in past 12 months?  1 Yes 2 No 9 L  Part II. Other significant condexaminer? 1 Yes 2 No  27 Manner of Death 1 Natural 5 Period Accident In Natural 5 Suicide 6 Cd 4 Homicide 29a Certifier (Check only 0ne) 2 Medical E	d.    AMENDED     13,140     23c. If yes,     1   Live     4   Preg     9   Unkrown     9   Unkrown     10   28a. Date     Aug 19     28a. Date     Aug 19     28a. Pla     (Specify     Physician: To the be     xaminer: On the basis     and manner	Inpatient 2 Ele of Injury - At home of Major Road instrument and time of death and the state of Injury - At home of Injury - At home of Injury - At home of Injury - At home of Injury - At home of Major Road instruments of examination and	2 Fet h 5 Oth  R/Outpatient 1710 hrs he, farm, stree / Highway , death occurr	al death 3	of Death (Che Other Work?  as 2 No inding, etc.  e and place, a death occurre	23e Did to  1 Yes  24a Was autop perfor 1 Yes  28d Describe Ejected occ  28f. Location (sor Town, Sor Town	Month  bbacco use control  2 No 3  an 24b No 3  an 24b No 3  an 24b No 1  Residence 6 now injury occurrupant auto a  Street and Number state)  464, Point of se(s) and manner and place, and dependence a	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other: Scene  Ted auto collision  Ter or Rural Route Number, Cite Rocks, MD  The as started due to the cause(s)  The action of the cause of th
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death evertificate be exequined 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial.	Certification: To Be Completed by Physician/Medical	events resulting in death) Lass  UNPENDED  IF FEMALE: 23b Was decedent pregnant in past 12 months?  1 Yes 2 No 9 UPART III. Other significant condexaminer? 1 Yes 2 No 27 No 27 Manner of Death 1 Natural 5 Period Accident In Natural 5 Vaccident In Suicide 6 Condexaminer 1 Certifying One) 2 Medical E  29b Signature and title of certification of the significant condexaminer?  20 Accident In Certifying One) 2 Medical E  29b Signature and title of certification of the significant condexaminer?  30 Name and address of persons and significant condexaminer?	d.    AMENDED     3,140     3,140     1   Live     4   Preg     9   Unkrown     9   Unkrown     1   Live     4   Preg     9   Unkrown     28a Data     Aug   19     28e Pla     28e Pla     (Specify     Physician: To the be xaminer: On the basis and manner iffer	Inpatient 2 Electric and Injury h. 2006 1 Stated St	2 Fet h 5 Oth ulting in the un  R/Outpatient 18b. Time of In 1710 hrs he, farm, stree / Highway , death occurr //or investigati	al death 3	of Death (Che Other A Nur Vat Work? es 2 No inding, etc. e and place, a death occurre number 1.E.	23e Did to  1 Yes  24a Was autop perfor 1 Yes  28d Describe Ejected occ  28f. Location (sor Town, Sor Town	Month  bbacco use contr  2 V No 3  an 24b V  say  med? 2 No 1  Residence 6  now injury occurr  upant auto a  Street and Number  tate) 464, Point of  te(s) and manner  and place, and d	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other: Scene  Ted auto collision  Ter or Rural Route Number, Cite Rocks, MD  The as started due to the cause(s)  The action of the cause of th
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	UNPENDED  IF FEMALE: 23b Was decedent pregnant in past 12 months?  1 Yes 2 No 9 L  Part II. Other significant condexaminer? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pereceived to Medical E  29a Certifier 1 Certifying (Check only 1 Check only 2 Medical E  29b. Signature and title of cert  30. Name and address of pers Ling Li, MD Assis	d.  23c. If yes, 1 Live 4 Preg 9 Unknown 9 Unkributing  28a Date Aug 19  28e. Pla 28e. Pla 28e. Pla 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 28e. price 38e. price 48e. price	Inpatient 2 Electric and Injury h. 2006 1 Stated St	2 Feth 5 Oth Ulting in the unu	al death 3	of Death (Che Other A Nur Vat Work? es 2 No inding, etc. e and place, a death occurre number 1.E.	23e Did to  1 Yes  24a Was autop perfor 1 Yes  28d Describe Ejected occ  28f. Location (sor Town, Sor Town	Month  bbacco use contr  2 V No 3  an 24b V  say  med? 2 No 1  Residence 6  now injury occurr  upant auto a  Street and Number  tate) 464, Point of  te(s) and manner  and place, and d	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other: Scene  Ted auto collision  Ter or Rural Route Number, Cite Rocks, MD  The as started due to the cause(s)  The action of the cause of th

	4		State State Registrar	of Maryland /	Department o	f Health and Mo of Death	ental Hygie		28906
×	Physici		1. Decedent's Name (First, Middle, Last)  LLGANA  C	BASI	1		2. Date of Death Month	Day Year 2001	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and  ANNE ANNE  5. Social Security Number  213-62-0111  6. Sex  1 M 2 X	number) e ( Med 7. Age (In yrs. last)	4b. City, Tow	n, or Location of Death  NUMPE  If Under 24 Hrs.  ys Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death	
	Maryland f ehow led at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arundel		own or Location				10d. Inside City Limits 13√ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number	Arnol	10f. Zip Cod	Ө	10g.	Citizen of What Cou	intry?
	seth w		900 Forked Creek Rd  11. Marital Status 12. Was D	ecedent Ever in U.S.	2101	2 of Hispanic Origin? (Spe		S • A	iona fadina
036	ours after d	by Funeral	1 Never Married 2 Married 1 Yes.	Forces?	If Yes, specify (	cuban, Mexican, Puerto F	Rican, etc.)	Black, White	, etc.
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Macalcal Examiner must be notified at	Completed		e (1-4or 5+)	life. DO NOT use re	ne during most of workin tired)	ng	Kind of Business/li	,
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Corperate I	18. Mother's Name		amily Bus: den Sumame)	iness
lan	Aental Aental rked c	To Be	Frank E. Basil			Sophie	Chotas	,	
lary	permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked any Injuty or other traumatic evone.		19a. Informant's Name/Relationship (Type, Print)		9b. Mailing Address (Str	eet and Number or Rural	Route Number, Ci		
o,	1 and Health am 27 thar t		David Roberts / Husbar 20a. Method of Disposition	20b. Place	00 Forked C	Da		land 2101 Location - City or T	
altimore,	Pages ent of nt: If It		1 ☐ Burial 2X Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State ceme	itery, crematory or other	place)			
a	ormit.		21. Signature of Funeral Service Licensee	Nati	22. Name and Ad	ory Aug. 3 dress of Facility Jos	eph Gawle	er's Sons,	Inc.
80	80 5 5 9		Williamy K. Su	1	5130 Wis	consin Ave	N.W. Wash	nington D.	
	Physician /Medical		23a. Part1. Enter the distase, or complications the shock, or heart failure. List only one cause (Immediate Cause (Final disease or condition resulting in death)	rterios	clerotic	dying, such as cardiac or	respiratory arrest,	sense	Approximate Interval Between Onset and Death
1984	Examiner		Due	to (or as a consequence	ce of):				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence	ce of):				
8760,	ate be executed hysicien and the buriat-transkt		resulting in death) Last Due	to (or as a consequence	ce of):				
687	ficate g physics as the	edical	d						
O. Box	s that the death certificaned by the attending plants and detached for use as t	Physician/Me	in the past 12 months?	outcome of pregnancy re birth 2  Fetal dea egnant at time of death iknown	ath 3 Ectopic pregna			23d. Date of deliv Month	ery Day Year
rds, P	6 0 0	۵	Part If. Other significant conditions contributing t	o death but not resulting	g in the underlying cause	given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Vital Records,	The taw ete has b page 2 sl	Completed					24a. Was an autopsy performed 1 Yes 2 🔀	? prior to co	oppsy findings available ompletion of cause of
Vita	Physicien: Th r this certificete ral director, pag	Be	25. Was case referred to medicat examiner?			26. Place of Death			
ō	ling Phys I. After this Tuneral di	tion: To	27. Manner of Death 28a. De		D. Time of 28c. Injury		ne 5 Residence 8d. Describe how in	6 □Other (Speci njury occurred	fy)
DIVIS		Certification:	3 Suicide 6 Could not be	ace of Injury - At home, littling, etc. (Specify)	farm, street, factory, offi	ce 2	8f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Director completely filled in	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To 2 Medicat Examiner: On the and n	the best of my knowled e basis of examination lanner stated.	dge, death occurred at the and/or investigation, in m	e time, date and place, and opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
1	Vithin 2 To the complet	Σ	29b. Signature and title of certifier  Millim P. C.	Je, n	puty 29c. Lio	0 60 5	29d.	Date signed (Month,	Pay, Year)
·			30. Name and address of person who completed of		a) (Type, Print)	95 A	meric.	A 210	35
	Sta Registr		AUG 2 8 2006	Registrar's Signature	Sparle				

			for State Registrar	State	of Marylan		rtment of H		Mental Hy			28907
F	hysici /Medic		Decedent's Name (First, Middle, Lillian	R.	BAKER				2. Date of De August		<sup>ау</sup> 200б <sup>еаг</sup>	3. Time of Death 10 A. M
	Examin		4a. Facility Name (If not institution, Shady Grove Adv				4b. City, Town, or Rockv1				c. County of Deatl Montgor	nery
	uneral rector		148-12-4161	5. Sex 1 □ M 2 <b>]</b> ∑ F	7. Age (In yrs. I 95	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Bi	rth ay,7 ear	9. Birth New	pplace (State or Foreign Place Sey
Maryland	a-f ehow	tor	Usual Residence of Decedent	each		nton E						10d. Inside City Limits 1 XYes 2 No
h with the	23a or 28 at be not	Funeral Director	10e. Street and Number 2520 NE 1st Co	urt, Apt	. 413		10f. Zip Code 3343	5		10g. C	itizen of What Co	untry?
.UU.SO hours after death with the Maryland	nd other then "natural", or items 23a or 28e-1 ehow event, itte Mudical Expriliter must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Fo	2 <b>□</b> ₩0 ve	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 TNo	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
CTZT5-0036 within 72 hours af	then "natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (	1-4or 5+)	16a. Decede (Give k life. D Homen	ent's Usual Occupa ind of work done of O NOT use retired laker	ation furing most of w	orking		Kind of Business/I	ndustry
/land Z	arked other atic event,	d)	17. Father's Name (First, Middle, La Abraham S					18. Mother's Na	ame (First, Middle Yetta L	, Maide ubin	n Sumame)	
and 2 sho	importent: If item 27 is marked cent injury or other traumatic events.	N		daughter		2520			.413, Bo	ynto	n Beach,	FL 33435
altimore, mit. Pages 1 a partment of Hee	tent: if ite		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	cify)	State	emetery, crem norah G		em. Aug		Wes		each, FL
Depart	eny in		21. Signature of Fureral Service (	By		2	54 Carro	11 St.,	NW, Was	hing		eral Home, Inc 20012
	sician edical		23a. Part1. Enter the issease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	caused the death each line.  Uroseps  (or as a consequ	sis	r the mode of dying	g, such as cardia	ac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death WEEK
pe	miner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Cerebro (or as a consequent Atrial	ence of):	ar Accid	ent				2 weeks years
. BOX 08 / 00, death certificate be execut	physicien and s the burial-transit	dicai	resulting in death) Last	Due to	(or as a consequ	ence of):						
.O. DOX of	igned by the ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	tcome of pregnar pirth 2 Fetal nant at time of de own	death 3 □	Ectopic pregnancy Other (specify)				23d. Date of delin	very Day Year
law requires that the	been signed b	by	Part II. Other significant conditions HTN	s contributing to d	eath but not resu	iting in the und	derlying cause give	in in Part I.		tobacco Yes 2	_	the cause of death? bably 4 XUnknown
The law	ate has page 2	Completed							24a. Was auto perfo 1 □ Yes	psy ormed?	death?	opsy findings available ompletion of cause of 2 11/10
OI VIII	this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			ER/Outpatient		r: 4 ☐ Nursing		dence	6 ☐ Other (Special	fy)
To the Hospital or Attending Physicien: within 24 hours after death.	To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1	t be 28e. Place	of Injury th, Day Year) of Injury - At horng, etc. (Specify,	28b. Time of Injury		at ? ′es 2 □ No	28d. Describe  28f. Location ( City or To	Street a	nd Number or Rui	al Route Number,
Hospital of 24 hours aft	Funeral Di stely filled in	edicai Cer	29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the b	best of my know	vledge, death	occurred at the timestigation, in my op	e, date and plac	e and due to the	causels	and manner as	stated. to the cause(s)
To the within	To the	Me	29b. Signature and title of certifier	9	Bu	-	29c. License	number 0 6 4 4 6	7	29d. Da	ate signed (Month)	Day, Year)
(			30. Name and address of person where Rebecca	Barker	2 9901	Medica	1 Center	Drive,	Rockvil:	le,	MD 2085	
F	Sta Registra		31. Date filed (Month, Day, Year)	2006	egistrar's Signat	doe	le le					

		For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and M Death		ene 20	06 2890
		Decedent's Name (First, Middle, Las	1)				2. Date of Death		3. Time of Death
Physic		David Allen Bo	oyer				August	31 200	
/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of [	
Examili	TOT	Beverly Healthca			Hagers			M	ashington
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. i	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
Director		215-44-9865	ZM 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day, Y Sept.25.	1945	Mary land
		Usual Residence of Decedent	- 0	<u> </u>			осрт (2)	1313	rior y roma
ylan		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examinar must be notified at	to	Pennsylvania Fultor	,	Bi	g Cove Ta	nnerv			1 ☐ Yes 2XXNo
r 284	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	t Country?
38 o		2584 Covalt Rd			1721	2		US	• ^
deeti	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. \		ispanic Origin? (Spanic Origin?)	ecify Yes or No-	14. Race - /	American Indian,
ther the	Ē	1 Never Married Married	Amed Forces? 1 ☐ Yes 2XX	1			Rican, etc.)	Black, V	Vhite, etc.
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🔾 💢 No	Specity:		Specify:	White
2 ho	Completed	15. Decedent's Ed		16a. Deced	dent's Usual Occup	ation	16	6b. Kind of Busine	
in 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give life. l	kind of work done of DO NOT use retired	during most of work 1)	ing		
the in	E	10	College (1-401 5+)	Ow	ner/Opera	tor		Barbe	er Shop
be filed ital Hygi od other	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
z should be lied within 72 hours after deem with the marylan and Menhall Hygiene and Menhall Hygiene is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	To B	David Samuel Boy	/er			Sylvia	Jean Well	er	
mar mar	-	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Run			te, Zip Code)
는 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다		David Scott Boyer	- Son	1295	4 lane's	Run Rd. E	Ria Pool I	MD 2171	1
Heal Heal		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			c. Location - City	
permit. Pages 1 and 2 should be Department of Health and Menta Important; if Item 27 is marked eny injury or other traumatic es once.		XXBurial 2 Cremation 3	Removal from State		natory`or other plac	1			
Transition .		4 ☐ Donation 5 ☐ Other (Specify  21. Sign ure of Funeral Service in a						gerstown	.Maryland
Depe mpo my i		21. Signature of Purieral Service 1.com	, , , , , , , , , , , , , , , , , , ,			Fine Faily Hon			1 445 04505
40244		1 mg	281						+,MD 21795
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. Alteroscelo	atti	1 cando	icovancul	Dens Den	u ane	Onset and Death
/Medical		resulting in death)	Due to (or as a consequ	uence of):	Cocco	( o v o oceo			Truns.
Examiner		*	premo	mua					2 days.
	ner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		_				1
cuted	Examiner	that initiated events	o mul	time	-cliro	26			(54caro.
an ar		resulting in death) Last	Due to (or as a consequ	uence of):					0
ficate be executed physician and is the burial-transit	dical		d						<u>.</u>
tifica ig ph as th	ed							- 1	1
eath certifi ettending for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Oratosis sussessis			23d. Date of	delivery
death e ette d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
that the de ed by the detached	Physician/Me	9 Unknown	9□ Unknown						
The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Y P	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
uire: Sigr Id be	d by						1 ☐ Yes	2 □ No 3 □	Probably 4 Munknown
w requir been si should	Completed						24a. Was an	24h 14/	e autopsy findings available
e lav hes je 2	m d						autopsy performe	prior	to completion of cause of
i: Th					-				Yes 2□No
Attending Physicien: The la r death. ector: After this certificete hes by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		10#		(Check only one)		
shys this c	၉	1 162 5 740		ER/Outpatien		4 VX Nursing Ho	me 5 Residence		Specify)
Viter	Certification:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe how	injury occurred	
eath or: A	cati	2 Accident investigation				Yes 2 □ No			
efter de Direct	Ħ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,
in the hospital or Attanding Prinin 24 hours efter death. The Funeral Director: After the mpletely filled in by the funeral	Cer								
To the Hospital within 24 hours e To the Funeral I completely filled	cal	29a. Certifier 1 Certifying Phy	vsician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the tim	ne, date and place,	and due to the caus	se(s) and manne	r as stated.
in 24 he F plete	edical	one)	and manner stated.	aon ana or in	restigation, in my 0	Pillion, Geaul Occurr	ovatule time, date	and place, and	Gue to the Cause(s)
vithin 2 To the	Σ	29b. Signature and title of certifier	11		29c. License		29d	I. Date signed (M	
18		Jungen J	18 May		102	8365		8-31-1	0.6
".H		30. Name and address of person who d	ompleted cause of death (Item	23a) (Type,	Print)				
1		19AW 240 5	ompleted cause oldeath (Item 32. Registrar's Signal	FR I	ulles St	reel- H	age is ter	un Mi	21740.
St	ate	31. Date filed (Month, Day, Year)	32. Aggistrar's Signal	ture			V		
Regist		AUG 3 1 20	006 /	4. Do	als)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per dvr 8859 9-13-06 vt

		1 - For State Registrar						Death		lental Hy		20	06	2890
Physici	ian	1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month			Year	3. Time of Deat
/Medio		NELLIE MARIE								09 -	- 02	2-	<del>-06</del>	1:15
Examir	ner	4a. Facility Name (If not institution, g						Location of	of Death			. County o		
F		MORAN MANOR NT 5. Social Security Number 6.		)ME 7. Age (In yrs.	last hirthday		STERN or 1 Year	PORT If Under	24 Hrs.	8. Date of Bir		ALLE		lace (State of Con
Funeral Director		215-18-8222	1□M 217 F	88		Months		Hours	Min.	07-11-	y, Year,		Coun	lace (State or Fon try) NUM • WV
D.		Usual Residence of Decedent								07-11-	1710		DAKI	NOPI, WV
arylar show	-	10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City Lin
8a-f	Director	MD ALLEGA	ANY	WE	STERNP									1 X Yes 2□
with the		10e. Street and Number				10f. Zi	p Code				-	izen of W	hat Coun	itry?
or death with the Marylar teme 23e or 28e-f show er nest be notified at	era	25701 SHADY I	ANE 12. Was Dece	dent Ever in I	19 13		562	cnania Ori	gin? (Coo	ecify Yes or No		US	Amaria	an Indian.
hours after death with the Maryland ture!, or iteme 23e or 28e-f show al Esamiliar naist be notified at	Funeral	1 ☐ Never Married 2 ☐ Married	Armed For	ces?	,	If Yes, spe	cify Cuba	n, Mexican	n, Puerto	Rican, etc.)	,-		, White,	
el', o	P	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Da	0		1 ☐ Yes	2XNo	Specify:				Specify:	WHIT	ΓE
72	Completed	15. Decedent's I (Specify only highest g		-	16a. Dece	dent's Usu	al Occupa	ation	t of works	70	16b. K	ind of Bus	iness/Inc	lustry
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filed w Hygier other ti		17. Father's Name (First, Middle, Las			HOUS	EWIFE	<u> </u>	40.44.4				MESTI		
ntal h	Be		st)							(First, Middle			)	
should ind Meni	ပ္	JOHN JOSE  19a. Informant's Name/Relationship	(Type Print)		10h Mailie	an Address	c /Stroot o			HILLIN( Il Route Numb			444 Ti-	0-4-1
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Hea Hea tem	1	20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	me of			ERNPORT		2130 ocation - C		wn, State
ages ent of nt: If i		1 ☐ Burial 2 XCremation 3 4 XDonation 5 ☐ Other (Spec		State	cemetery, crei U MEMOI	*			9-8	-06		RGANT	•	
permit. Pages Department of the importent: If its eny injury or of the importent.		21. Signature of Funeral Service Lice		2	/ 22	Name a	HOMA!	s of Facilit		GISTRY	1101	COLLINA	01111	
20 E e a		23a. Part1. Enter the disease, or conshock, or heart failure. List only	6)06	you		MORG	ANTO	VN WV	265	06				
Carle be executed by Action of the private transit the private transit the private transit the private transit	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consec	quence of):	исе								Onset and Death
e attending of for use as	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 10 No 9 □ Unknown	4□Pregna 9□Unkno	rth 2 ☐ Feta unt at time of d wn	al déath 3 death 5 death	Ectopic p	pecify)	n in Part I		23a Did t		23d. Date Mont	h	ry Day Year e cause of death
ine iaw requires that the ate has been signed by th page 2 should be detache				201 041 1101 100	and girthout	idenying (	2036 GIV6	mmran.			es 2		☐ Proba	. 4:
	Completed									24a. Was autop perfo 1  Yes		de	ath?	esy findings available pletion of cause
centi	) Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
£ 76	: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		JA	4 2 140		ne 5 Resid				)
th. Afte	tion	1 Natural 5 Pending 2 Accident Investigation	(Month	, Day Year)	Injury	м	28c. Injury Work 1 □ Y	? ′es 2.⊡h		.ou. Doscribo i	iow arqui	youdine	•	
within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined	4   200. Flace (	of Injury - At higg, etc. (Specil	ome, farm, str	eet, factor	y, office		2	28f. Location (5 City or Tox	Street an vn, State	d Number )	or Rural	Route Number,
24 hour	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the teminer: On the ba	sis of examina	wledge, death tion and/or inv	occurred restigation	at the time, in my op	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s)	and manr place, an	ner as sta d due to	ated. the cause(s)
To the comp	Me	29b. Signature and title of certifier	00			290	c. License	number			29d. Dat	e signed (	Month, E	Day, Year)
		> worker	this 1	40			טט כ	5532	-5		Ser	02	, 20	006
		30. Name and address of person who											,	
		wonsock shir			M Ter		e Fr	ostbi	ure	MD =	153	32		
Sta	te ar	31. Date filed (Mohth, Day, Year)		gistrar's Signa	ture	) >=								

	>-		Tor State Registrar	State of Ma	ryland /	Depa Cert	rtment (	of He	ealth a <i>eath</i>	ind Me		giene leg. No.	2006	5 289	10
	Physici		Decedent's Name (First, Middle, La  Josephus	,	Outch	nin					2. Date of Dea Month August	Day	( 200		
	/Medic Examin		4a. Facility Name (If not institution, giv Washington Adventist				4b. City, To	wn, or L	Park	f Death	714,3	4c.	County of De	eath	
	Funeral Director		277 70 7707	ex 7. Age ✓ M 2□ F	(In yrs. last i	birthday) Yrs.	If Under 1 Months E	Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	7, Year)		irthplace (State or Country) orth Caroli	
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation							10d. Inside City	/ Limits
	e Man	ctor	Maryland Prince G	eorge's			]	Fores	stvill	.e				1 XX es 2	2 🗌 No
	th with th	Funeral Director	10e. Street and Number 3317 Walters Lane Apt	. #201			10f. Zip Co	ode	2074	<b>.</b> 7		10g. Citiz	u.S.A.	Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Madical Example must be inclified at ance.	۾	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Evaluated Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		If	/as Deceder Yes, specify ☐ Yes 2X	Cuban,	panic Orig Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)		Black, Wi	nerican Indian, hite, etc. Black	
Maryland 21215-0036	within 72 ho ene. then *natur the wedical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) /Lh grade	ducation ade completed) College (1-4or 5+		(Give k life. D	ent's Usual ( kind of work ( 10 NOT use ) stodian	done du retired)	ring most	of workin	g	Mon	of Busines Egamery Educati	County Bos	ard
land 2	uld be filed Mental Hygi irked other itic event,	To Be C	17. Father's Name (First, Middle, Last, Jake Outchin	)				1	8. Mother		(First, Middle, Rhodie C	Maiden .	Sumame)	<u> </u>	
Mary	alth and I		19a. Informant's Name/Relationship ( Helen L. Outchin (Da								Route Numbe Forestvi				
altimore,	ages 1 a ant of Hei nt: if itsm y or othe	- 1	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		ceme	itery, crem	ition (Name atory or othe n Cemet	ir place)	1	Da			-	or Town, State , Maryland	
Baltii	permit. F Departmo Importer any injur		21. Signature of Funeral Service Licen		Zw.	22.	Name and	Address	of Facility	Ro	Ilins Fu shington	neral	Home,	Inc.	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused to one cause on each line	).	o not ente	r the mode o	of dying,	such as o	cardiac or	respiratory arr	est,		Approximate Interval Betwee Onset and De	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence te Cano									Unknown	
	ted t	Examiner	Sequentially list conditions, if any, reading to inhubilate cause. Enter Underlying Cause (Disease or injury	Diabeta		seroffic								Unknown	
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.O. Box 6	death certifi e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome o  1 Live birth 2  4 Pregnant at t	Fetal dea		Ectopic preg Other (spec					2	3d. Date of d Month	elivery Day Ye	ear
J.	9 P 9	by	Part II, Other significant conditions	contributing to death but	t not resulting	g in the un	derlying cau	se given	in Part I.					to the cause of dea	
Records	e law has b	Completed									24a. Was autop perfor 1 Yes	sy med?	24b. Were prior t death		vailable use of
Vital	Physicien: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	Hospital:				Cther	-		(Check only o				
of	Phys rthis ral di	on: To	1 ☐ Yes 2 🛣 No  27. Manner of Death  1 📆 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	281	Outpatient  b. Time of Injury	280	Injury a	at	2	ne 5 Resid			oecify)	
Division	eati for:	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	OB Blace of Injur	ry - At home (Specify)	, farm, stre	M eet, factory, o		es 2 🗆 N		8f. Location (S City or Tow			Rural Route Numb	er,
_	Hospite 4 hours Funere	edical Ce	29a. Certifier Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner state	examination	dge, death and/or inv	occurred at restigation, in	the time my opi	e, date and nion, deal	d place, a th occurre	nd due to the old at the time, o	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
	To the within 2 complet	Med	29b. Signature and title of certifier	and market state	6U.	7-		icense	-		/	29d. Dat	e signed (Mo	onth, Day, Year)	
,	41)	17	30. Name and address of person who		ath (Item 23	la) (Type, I	Print)			4ryla		2	5//2		-
	Sta	ate	D. Michael Coleman,  31. Date filed (Month, Day, Year)  SFP 0 1 2006	32. Registra		)									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 2006 LINDA LEE ELLIS CLUKEY 6:28 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGES LAHREL. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2KXF Days Yrs. JULY 27, Director 63 1943 214 48 9337 WASHINGTON, DC Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. fnside City Limits items 23a or 28a-f show there was be notified at XX Yes 2 No Director MD PRINCE GEORGES LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 6832 FLAGSTAFF STREET UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Exeminer of 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: þ Specify: WHITE 3 ☐ Widowed X X Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) Coflege (1-4or 5+) 11TH OWN HOME HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES EUGENE ELLIS ALLENE CATHERINE MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 st of Health ar 190 RAY ST. JAMES W. CLUKEY / SON PORTLAND, ME 04103 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 08/31/2006 ALEXANDRIA, VA 22. Name and Address of Facility RAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CELLULITIS WITH OSTEOMYLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed RIGHT LOWER LOBE PNEUMONIA Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ page 2 should be CANCER OF BREAST 1 Yes 2 No 3 Probably WXUnknown Completed DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2□ No XXNo 1 Yes Division of Vital Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXYes 2□ No 1 Inpatient XX ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1XXNatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnitury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 AUGUST 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED SADIQ 14333 LAUREL BOWIE RD. #208 LAUREL, MD 20708 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 1

		ľ	1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of l</i>			g. No. 200	5 2891
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month		3. Time of Death
1	/Medio	al	Tommy Andrue  4a. Facility Name (If not institution, giv.			Ab Ciby Town or	Location of Death	August	5, 2006 4c. County of Deatl	8:50 A M
1	Examir	er	Suburban Hospita			Bethe			Montgome	
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	je (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign untry)
	Director		213-40-4140	<b>X</b> M 2□ F	62 Yrs.	Indiana Bayo	110010	Apr. 30	, 1944 Wes	t Virginia
	ow ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man,	ţor	MD Montgom	nery	Silve	er Spring				1 X Yes 2 ☐ No
	or 28	Direc	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co	untry?
	ath w	rai	3351 Hewitt Ave.				0906		USA	
40	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neture!; or iteme 23s or 28s-1 show other traumatic event, the Madical Examinationals is neitilised at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spi in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036	ei', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of works	ing	16b. Kind of Business/	ndustry
121	within ene. than "	Idm	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired andscaper	1)		Landsca	ndna
<b>d</b> 2	Hygir Hygir ent,	ပို	17. Father's Name (First, Middle, Last)	)	Бе	indscaper	18. Mother's Name	e (First, Middle, N		ping
lan	should be and Mental marked o	To Be	Calvin	Cosne	er		Onie		Aro	nhalt
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumattc event, the Ma		19a. Informant's Name/Relationship (						City or Town, State, Z	ip Code)
	and in 27 m 27		Deborah A. Cosne	r/ Wife	3351				pring, MD	20906
Baltimore,	8 = 5		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other plac	:e)		Coc. Location - City or	
Ħ	permit. Pa Departmen Important: eny injury	3	4 □ Donation 5 □ Other (Specifical Signature of Funetal Service Lice		Cosner C	2. Name and Addres			Second S	
Ba	permit. Departr Import		> Bredly H3	tem		tewart Fu				1550
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):  Cardifis  a consequence of):	ing Cance				Approximate Interval Between Onset and Death
68760,	tificate be executed ig physicien and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Thur of Due to (or as	mbo cy fo pe a consequence of:	nid-				
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rds, P.	w requires that the de been signed by the s should be detached i	ed by PI	Part II. Other significant conditions of	contributing to death b	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob 1 ⋈ e	acco use contribute to s 2 ☐ No 3 ☐ Pro	the cause of death?
of Vital Records,	The lay	Complet						24a. Was an autopsy perform	prior to o death?	opsy findings available ompletion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		o Don Othe	26. Place of Death			
ō	nding Physician: th. : After this certifice s funeral director, s	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	iry 28b. Time o	II 3U DOA	4 🗆 Nursing Ho	me 5 Resider	nce 6 Other (Spec	ify)
Division	Attending r death. ector: After by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, Da</i>	y Year) Injury		k? Yes 2 □No			
ivis	r Atte	tific	3 Suicide 6 Could not b 4 Homicide determined	286. Place of in	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
0	urs eff erai Di									
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best miner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	n occurred at the time evestigation, in my of	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the COMP.	ž	29b. Signature and little of certifier			29c. License	number	29	d. Date signed (Month	, Dey, Year)
			• UTM			NOU	20610		8/05/06	
	1		30. Name and address of person who	1 11	death (Item 23a) (Type,	Print) Old Geo	orghoun	Rd	1 1	
3	Sta Registi		31. Date filed (Month, Day, Year)  AUG - 7	2006 32. Registr	ar's Signature	Souls				

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cosner, Tommy osloslob

06-06517 Am	en	ded Item 20B per Please Type or Print in E Funeral Director of Maryland / Department of 1- For State Of Maryland / Certificate of	Black Indelible Ink		
Wheeler W. Clark	<	9/6/06 cs State of Maryland / Department of	Health and Mental Hy	giene	0000
	لي	Registrar		Reg. 2. Date of Death	No. 2005 289
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last)  Wheeler Wilson Clark SR.	ĺ		ay Year 2322 hrs
		4a. Facility Name (if not institution, give street and number)  4	b. City, Town, or Location of Death		4c. County of Death
		Memorial Hospital	Cumberland		Allegany
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min	1	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-07-4265 1 MM 2 F 9/ Yrs.		June 15	1915 Country) Mary Inval
any	ł	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>*</b>	5	Maryland Allegany Lonnconin	4		1 Yes 2 No
Maryla 28a-f	Director			10g.	Citizen of What Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.		10 Pershing Street	21539		U.S.A.
ath wit tems 2	ō١	1 Nover Married 2 Married Armed Forces?	s Decedent of Hispanic Origin? ( Spe es, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - American Indian, Black, White, etc.
ter de	/ Fun	1 Yes 2 X No	Yes 2 No specify:		Specify: White
ours al atural	g b		's Usual Occupation (Give kind of wo		6b. Kind of Business/Industry
16 n 72 h nan "n	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	1		Tire
5-0036 iled within 77 Hygiene.	E O	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Mai	
215 be filed ntal Hy rked of	Be C	Harry Clark  19a. Informant Name/Relationship (Type, Print)  19b. Mailing	Gertru	de MA	e Green
S may be made as a second	2		Address (Street and Number or Ri	ural Route Numbe	er, City or Town, State, Zip Code)
MD and 2 sho alth and m 27 is		Wanita M. Hausrath - Daughter Box13  20a Method of Disposition  20b. Place of Disposi	198, Fort Ashby, tion (Name of cemetery,	Date 2	20c Location - City or Town, State
Baltimore, M semit Pages I and 2 Department of Health Important: If item 2		cromatory or oth	or place)		
Baltimo permit Pag Department Important:		4 Donation 5 Other Specify: Rest 21. Signature of Funeral Service Licensee 22. N	1awn Mem Gdn e 7	3,2006	La Vale MD. Kenzie Famound Home M
Bal permi Depar Impo		As E Mr Kemp	PAH-COMING MATY	Inul 21	1539
Physician		33. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac or	respiratory arrest	, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Contact Gunshot Wound of Head			Death
LAGITITIC		or condition resulting in death)  Due to (or as a consequence of):			
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated control country country in a consequence of):  Due to (or as a consequence of):			
ecuted and and transit		events resulting in death) Last Due to (of as a consequence of).			
iox 68760, each certificate be execut e attending physician and for use as the burial - tra	dical	UNPENDED AMENDED			
68760, certificate be nding physicise as the buri	an/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	tal death 3 Ectopic pregnar	nav	23d Date of delivery  Month Day Year
c 68 certif	0	past 12 months?	tal death      3 Ectopic pregnai her <i>(Specify)</i>	icy	l Month
Box e death c the atten	Physi	1 Yes 2 No 9 Unknown 9 Unknown		00 01111	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	1	acco use contribute to the cause of death?  2 ✓ No 3 Probably 4 Unknown
S, P quires then signed and be d				24a. Was an	
Ord law red has be 2 shou	Completed			autopsy perform	ed? death?
Rec The ficate	Sol		26.Place of Death (Check of	1 Yes 2	No 1 Yes 2 No
'ital sician: is certi lirectol	Be	25. Was case referred to medical examiner?  1	Othor -		esidence 6 Other:
Division of Vital Records, ral or Attending Physician: The law requirers after death.  "I Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should	): To	27. Manner of Death 28a. Date of Injury 28b. Time of I	njury 28c. Injury at Work?	28d. Describe ho Subject shot	
ivision of \\ 1 or Attending Phy after death.  Director: After tt d in by the funeral i	Certification:	1 Natural 5 Pending Aug 30, 2006 1700 hrs	1 Yes 2 ✔ No		
ivis or At after d Direct	tific	3 V Suicide 6 Could not be 28e. Place of Injury - At home, farm, street		or Town, Sta	
Divisior Hospital or Attend 24 hours after death Funeral Director:	Cer	4 Homicide determined (Specify) Single Family  29a Certifier Bhysician To the best of my knowledge, death occur		<u>_</u>	Street, Lonaconing, MD
To the Hos within 24 h	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Medical Examiner: On the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the basis of examination and/or investigated the control of the c	red at the time, date and place, and tion, in my opinion, death occurred a	t the time, date ar	nd place, and due to the cause(s)
To the within To the comple	Med	and manner stated  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		January San Shall non	O.C.M.E.		August 31, 2006
		30 Name and address of person who completed cause of death (Item 23a)			
5			Penn Street, Baltimore, MD	21201	
Si Regis	tate trai	JI F 1111D 1886c A	£ 5		
	_	3	(A) (A) (A) (A) (A) (A) (A) (A) (A) (A)		

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Amended Item 20B per

			1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artment of rtificate o	Health and f Death	d Mental Hy	/giene Reg. No	200	6 28911
	Physici		Decedent's Name (First, Middle     MAUDO, B., CAB:						2. Date of D Month	Da	y Yea	3. Time of Death 10:50 AM
	/Medic Examin		MAURO B. CAR 4a. Facility Name (If not institution		umber)		4b. City, Town	, or Location of De			. County of De	
	Funeral		13717 WOODLARK D. 5. Social Security Number	RIVE 6. Sex 1⊠M 2□ F	7. Age (In y	rs. last birthday)	If Under 1 Ye Months Da		Hrs. 8. Date of B	irth ay, Year)	MONTGON 9. B	IERY irthplace (State or Foreign Country)
	Director		578-56-0365 Usual Residence of Decedent		71	Yrs.			AUGUST	01, 19	935 E	CUADOR
	arylan ehow	-	10a. State 10b. County		10c.	City, Town or Li	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M	Director	MARYLAND MONTG  10e. Street and Number	OMERY			ROCKVII			10a Ci	itizen of Whal (	
	3a or	Ī	13717 WOODLARK D	RTVE.			Tot. Zip cod	20853		109.01	U.S.A.	
	death me 2	Funeral	11. Marital Status		cedent Ever in	1 U.S. 13.	Was Decedent		? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - An	nerican Indian,
920	be filed within 72 hours after death with the Maryland stal Hygiene.  dother then "naturel", or Iteme 23a or 28a-f ehow event, the Modical Examinar must be multified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	ied 1 ⊟Yes If Yes. G	2 🔯 No live		1 Ø Yes 2 □ I	No Specify:	ECUADOR		Black, Wi Specify:	CAUCASIAN
2-0	72 ho	eted	15. Deceden	I's Education	)	16a. Dece	denl's Usual Oc	cupation ne during most of	workina	16b. K	Cind of Busines	s/Industry
21215-0036	within ane. then	Completed	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use rea	ired)	•		CELE	
	D 0	Be Co	17. Father's Name (First, Middle,				PECHANIC	18. Mother's	Name (First, Middle	e, Maider	SELF n Sumame)	
/lan	Mental Mental triked	To B	FRANCISCO CA	RRERA				ME	RCEDES BENI	TEZ		
Maryland	l 2 sho		19a. Informant's Name/Relations						Rural Route Num			
e,	The Health		AMALIA CARRERA -  20a. Method of Disposition	WIFE	206	. Place of Dispe	osition (Name of	1	OCKVILLE, N Date	·	AND 20853 ocation - City of	
ē	Pages ent of nt: If It		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State PA	ARKLAWN M	matory`or other ; EMORIAL PARTENS	ARK 8/	28/2006		CKVILLE.	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth eny Injury or other traumatic event		21. Signature of Funeral Service		'''.\ ⊀	2	2. Name and Ad	dress of Facility	HINES-RINAL	DI FU	NERAL HO	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de each line.							Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ASTATIC	RECTAL CA	NCER					2 YEARS
	Examiner			b	O (OI as a COIIs	sequence or,						
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a cons	sequence of):						
8760,	icate be executed physicien and s the burial-transit	dicai Exa	that initiated events resulting in death) Last	c	o (or as a cons	sequence of):						
9	rtificate ng phy as the	Medic	15 55 W 5	0.		10-0-				- 1		
P.O. Box	The law requires that the death certificate be executed tte hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of preg birth 2 Fignant at time of nown	etel death 3	⊒Ectopic pregna ⊒ Other (specify				23d. Date of d Month	elivery Day Year
	quires that the signed by all be detacted	2	Part II. Other significant condition	ons contributing to	death bul nol r	resulling in the u	inderlying cause	given in Part I.				lo the cause of death?  Probably 4 Unknown
Records,	. The law requir cate hes been si page 2 should	Completed							24a. Wa auto peri 1 🗆 Yes	omed?	prior to	autopsy findings available o completion of cause of
Vital		BeC	25. Was case referred to medica examiner?						Death (Check only			
of <	Phys this al dii	은	1 ☐ Yes 2 ☒ No 27. Manner of Death			ER/Outpatie	W 30 DOX		g Home 5 🖾 Res			pecify)
	Jing After fune	atlon	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	of Injury nth, Day Year,	28b. Time o Injury	,	njuryat Vork? ☐ Yes 2 ☐ No	28d. Describe	now inju	iry occurred	
Division	ipitel or Attendours efter death leral Director: filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Plac	ce of Injury - Adding, etc. (Spe	t home, farm, st ecify)	reet, factory, offi	ce	28f. Location City or To			Rural Route Number,
	To the Hospitel or Attentwithin 24 hours effer deati To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 X Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	ne best of my k basis of exam nner stated.	knowledge, deat ination and/or in	th occurred at the	e time, date and pl y opinion, death o	ace, and due to the occurred at the time	cause(s , date an	s) and manner od place, and d	as stated. ue to the cause(s)
	To the Comp	ž	29b. Signature and title of certifie				29c. Lic	ense number		29d. Da	ate signed (Mo	nth, Day, Year)
	10			Momo				23308		AUG	UST 25,	2006
			30. Name and address of person VICTOR M. PRIEGO					100. RETHE	A TVGAM AGS	אט אט	817	
	Sta		31. Date filed (Month, Day, Year)					LOU, DEINE	PIAKILA	ND 20	OT/	
	Registi	ar	AUG 28	2006	Bus.	gnature Ap						

		For Stata Registrar	State	of Marylar			nt of He te of D		ind M	lental H	lygien Reg. N		06	28915	)
Dhysisis		1. Decedent's Name (First, Middle								2. Date of Month		ay	Year	3. Time of Death	
Physiciai /Medica		James Gregory	Curtin, S	er.		,				Augus				11:29 <sup>a M</sup>	_
Examine	r	4a. Facility Name (If not institution				4b. City	, Town, or		f Death		4	c. County o			
		Montgomery Get  5. Social Security Number	neral Hos	7. Age (In yrs.	last hirthday	if Linds	Olr or 1 Year	1ey If Under 2	24 Hrs	8. Date of	Ridh			lace (State or Foreign	_
Funeral Director		200-16-0789	1.3 M 2 ☐ F	81	Yrs.	Months		Hours	Min.	(Month, Nov.	Day, Year	24	Cour	nacy (State of Foreign nsylvania	
	- 1	Usual Residence of Decedent		01											_
yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits	
Mar a-1-e	į į	Maryland Mon-	tgomery	Si	lver Sp	pring	1							1 ☐ Yes 2 <sup>3</sup> ☐ No	
or 28	<u>ē</u> [	10e. Street and Number				10f. Z	p Code				10g. C	itizen of W		•	
ath w	<u> </u>	3330 North L					209						USA		
ite; Malylating ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Modical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marr  3 □ Widowed 4 □ Divorced	ied 1 X Yes	ecedent Ever in U Forces? 3 2 No Sive Dates: WW		Was Dece If Yes, sp 1 ☐ Yes	ecity Cubar	spanic Orig n, Mexican Specity:	gin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-	Black	- Amend k, White, White		
tural to ur			Year or	Dates: WW.	16a. Dece	dent's Us	ial Occuna	tion			16h	Kind of Bus	siness/lni	dustry	_
27 m	Completed	(Specify only higher	st grade complete	·	(Give	kind of w	ork done d use retired)	uring most	of worki	ng	100.	iting or ou.	31110338711	austry	
T the liane.	E	Elementary/Secondary (0-12)	College 5-	(1-4or 5+) <del> </del>	Compu	ıter	Syste	ems A	naly	st	U.S	. Gov	vern	ment	
othe file	a l	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	First, Mide	dle, Maide	n Sumame	<del>B</del> )		
Menta Wenta	0	James Francis	Curtin						Mar	ion O	tley				
and to ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Addres	s (Street a	nd Numbe	r or Rura	l Route Nui	mber, City	or Town, S	State, Zip	Code20906	
and and m 27 m 27 nar tr		Anne Marie Cur	tin/ Wife					re Wo						Spring, MI	)
Profit		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	m State	Place of Dispo cemetery, crea	natory or	other place			ot. 25		Location - (			
Peg tment tent:	-	4 Donation 5 Other (S	pecify)	Arli	ington N				2	006	Arl			Virginia	_
pomit. Peges : Depertment of h importent: if its any injury or of once.		21. Signature of Funeral Service	Licensee	ч						Funer, W,				, MD 20901	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the deat n each line.	th. Do not ent	er the mo	de of dying	g, such as	cardiac c	or respirator	y arrest,			Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	a	Cardio	15060	ton	1 6	Inc.	51					Onset and Death	
/Medical Examiner		resulting in death)	Due	o (or as a consec	quence of):	C									
	إ	Sequentially list conditions,	b	o (or as a consec	red									14-	_
pe Jist		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a consec	1	/	λ								
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	dical		1 A	CIA K	Polle	<u>ا</u>								Veas	
ficate ficate phys	ë		u			_							/	<i>y</i>	_
vequires that the death certification is a second of the standing should be detached for use as	ician/me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Testania	regnancy					23d. Date	e of delive	ery	
deatl		in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of o		Other (s					-	Mon	nth	Day Year	
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s the es the be de	2	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying	cause give	n in Part I.						ne cause of death?	
law requires es been sign	Ted led	Kecast	Janan	Ret	In	rich	CA			1	∐ Yes :	2 ∐ No	3 Prob	pably 4 dnknown	_
lawr les be	Completed	Demenh	1							24a. W	utopsy	Р	rior to co	psy findings available mpletion of cause of	
The peg	ទី	Perkinson	3 1) 150	130							erformed? s 2		eath?	2 No	
on or vital nec	g G	25. Was case referred to medica examiner?	-				0		of Death	(Check on	ly one)				
Physic this c	<u> </u>	1 Yes 2 No			ER/Outpatier			4 🗆 Nu		me 5 R				y)	_
After	5	1. ■Natural 5 □ Pendir	ng (M	te of Injury onth, Day Year)	Injury	" м	28c. Injury Work	:?` ∕es 2 🗀 !		200. 1003011	De now in	ury occurre	30		
or Attending effer death. Director: Affe lin by the fune	Ica	3 ☐ Suicide 6 ☐ Could	not be	ce of Injury - At h	ome, farm, sti					28f. Locatio	n (Street a	and Numbe	er or Rura	Il Route Number,	_
offer effer d in b	Certification:	4 ☐ Homicide determ	bui	lding, etc. (Speci	<i>(ty)</i>		.,,				Town, Sta				
	ledical C		ng Physician: To t Examiner: On the												
To th Within To th sompl	Me	29b. Signature and title of certifie	2 //	media	al Din	110-	c. License							Day, Year)	
11+1		I forband	K-MD	, - , C-D-, C			Do.	504.	10		00	P/23	3/0	6	
10		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	2	0:	,	. ~!	4	_			_
		Michae	1 Ker	r MIS	1810.	1 80	race	Phi	1.1	Ola	of P	40			
Stat Registra		31. Date filed (Month Day, Year, AUG 2 8	2006	Registrar's Sign	ature do	3456	P			C					

		,	1 - For Stete Registrar	State of	f Maryla	nd / Depa <i>Cer</i>	irtment of H tificate of L	lealth an Death	nd Men	tal Hygie	ene 20	06	28	916
		3	1. Decedent's Name (First, Middle, Last	")						Date of Death Month	Day	Year	3. Time o	of Death
	Physicia /Medic		Bennie	Lee Do	uglass					igust	26, 20		5558	BA M
	Examin		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, Town, or	Location of D	Death		4c. County	of Death		
			Prince Georges Ho	spital			Chever				Princ	e Geo		
	Funeral		5. Social Security Number 6. Se	x □M 2√2 F		s. last birthday)	If Under 1 Year Months Days		Min. (	Date of Birth Month, Day,	(ear)	9. Birthpla Countr	ce (State	or Foreign
-35	Director		271-30-6709	141 5 K	8.	5 Yrs.			Se	pt. 24	,1920	Geor		
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. C	City, Town or Lo	cation					100	d. Inside (	City Limits
	daryl f sho	ō	D.C.		Wa	shingto	n D C							s 2 No
	28a-	ect	10e. Street and Number		Wa	BIITHECO	10f. Zip Code			10	g. Citizen of W	hat Countr	v?	
	3a or	٥	5010 7th Place NW					20011			USA		•	
	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Evament missible rediffed at	Funeral Director	11. Marital Status	12. Was Dece		U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba		? (Specify	Yes or No-	14. Race	- America		
0	or ft		1 Never Married 2 Married	Armed For	2 No				Puerto Rica	n, etc.)		k, White, et		
0000	ral', o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da		'	I□Yes 2☑No	Specify:			Specify:	Blac	:k	
ה ה	72 h	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)		16a. Deced	lent's Usual Occupa	ation during most of	f working	16	6b. Kind of Bu	siness/Indu	stry	
7	Man Man	npl	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	DO NOT use retired	)			D			
7	led w lygier her ti		12th			Mainte	nance Dep				Priv			
משם	be find the	Be	17. Father's Name (First, Middle, Last)  Benjamin Simpson	1					Till:		aiden Sumame	9)		
N N	3 Mer narke	မှ				401 14 11					O: T	. 7		
	12 st h and 7 ts n traun		19a. Informant's Name/Relationship (T)  Yvonne 011ie/Daug				g Address (Street a							20774
ב ט	1 and Healt em 2 Ither		20a. Method of Disposition	511001	20b.	_			Date		oc. Location -			20774
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, natural; or frams 23a or 28a-f show any injury or other traumatic event, the Marical Exam and must be notified at Once.		1 Burial 2 ☐ Cremation 3 ☐ i		Jiaie		sition (Name of natory or other plac	- F	. / 0 0 0	- 1				
parillimor	artme ortani injury		4 □ Donation 5 □ Other (Specify,  21. Signature of Euneral Service License		() ()	-	emorial (				iitland		-	
ם	permil Depar impor any in		) DIMIC	577		1811			5538	Marli	al Hom oro Pi	ke	1 77	
	*		23a. Part1. Enter the disease, or comp	lications that co	aused the de	ath. Do not ente	er the mode of dying	g, such as car			le, Md.		Approxima	ite
١,			shock, or heart failure. List only commediate Cause (Final										nterval Be Onset and	
	nysician /Medical		disease or condition resulting in death)		iac Ar	ythemia						-	3 we	eks
	Examiner				onary								3 we	-leo
il		Je.	Sequentially list conditions, if any, leading to immediate		or as a conse								2 10.0	- NO
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Ď :	death certific	0	IF FEMALE:					············						
Š O	ath ca ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fe	tal death 3 [	Ectopic pregnancy				23d. Date Mor	ol delivery	/ Pay	Year
5	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	ant at time of	death 5	Other (specify)						-,	
Ĺ	hat th		Part II. Other significant conditions co	ntributing to de	eath but not re	esulting in the ur	deriving cause give	en in Part I		23e Did toba	cco use contri	bute to the	cause of	death?
Ś	w requires that the de been signed by the i should be detached	l by	Pulmonary Hypert	_		500mmg m 1110 ar	idony ing oddao give	OIT 31 T Q T T T			2 🗆 No			
cords,	redu	ete			. 1				_					
j E	has has	Completed	Chronic Respirat	ory ra	llure					24a. Was an autopsy perform	24b. V p	Vere autops rior to comp eath?	pletion of	cause of
	sician: The law s certificate has b irector, page 2 s		Cerebrovascular	accide	nt							☐ Yes 2	□ No	
VII de	stcial certif recto	Be	25. Was case referred to medical examiner?	Hospital:		6X	Othe	00		neck only one,				
5	Physical distribution	To I	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 📙		X ER/Outpatien 28b. Time of	I 3 DOA	4   Nursii			ce 6 Othe			
0	ding th. Afte fune	tlon:	1 Natural 5 Pending 2 Accident investigation	(Mont	of Injury h, Day Year)	Injury		k? Yes 2 □ No			, , ,			
	Attendii r death. sctor: A	flea	3 Suicide 6 Could not be	28e. Place	of Injury - At	home, larm, str	eet, factory, office		281.	Location (Stre	et and Numbe	er or Rural i	Route Nu	mber,
	ai or atte	Certificati	4 Homicide	buildir	ng, etc. (Spec	cify)				City or Town,	State)			
	ospit hours unera ly fille		29a. Certifier 1 Certifying Phy	sician: To the	best of my ki	nowledge, death	occurred at the tim	ne, date and p	olace, and	due to the cau	ise(s) and mar	nner as sta	ted.	
	To the Hospital or Atlanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Exam	and manr	asis of examir ner stated.	and/or inv	restigation, in my of	pinion, death (	occurred a	t the time, dat	e and place, a	na due to t	ne cause	S)
	2 8	Σ	29b. Signature and title of certifier	111	LINA	4_	29c. License	e number	22	11 100	d. Date signed	(Month, D.	ay Year)	
)	12)		· yeu				01	02	/ 3	1410	8/0	16/	06	
W.			30. Name and address of person who c	ompleted caus	e of death (It	em 23a) (Type,	Print)	No	111.	7/20	m	ハフ	175	76
人			31 Date liled (Month Day York)	IKIH	y 20	COL HOS	DITHL	JK (	LITE	VERI	1 1111	120	170	
13	Sta Registr		SEP 0 1 2006	- Ser )	egistrar's Sig	and "								

			1 - For State Registrar	State of M	arylar	id / Depa	artment o	of Health of Death		R	eg. No.	200	6 2891
	Physici	an	Decedent's Name (First, Middle	r section						2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	Jerome "		onat	to	4h Cihi Toi	vn, or Location		ugust	29,	2006 inty of Death	5:30 a M
	Examin	er	4a. Facility Name (If not institution 4203 Skyline	-	,		,	land	OI Death			nce Ge	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Y	ear If Under	r 24 Hrs. 8	Date of Birth			place (State or Foreign
	Director		224-86-2069	1 <b>₫</b> M 2 □ F	50	Yrs.	Months D	ays Hours	Min. J	Date of Birth (Month, Day, uly 26	, 195	6 Vir	ginia
	p		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryla f eho	ō		e George		itland							1 ☐ Yes 2 ☐ No
	r 28s	Directo	Maryland   Prince	e George	<u> </u>	Ittanu	101. Zip Co	de		1	0g. Citizen	of What Cou	intry?
	within 72 hours after deeth with the Maryland ene. Then "natural", or items 23a or 28a-f ehow na Medical Examinar must ke motified at	aiD	4203 Skyline	Drive			207	46			Unit	ed Sta	tes
	ems.	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Deceden	of Hispanic Or Cuban, Mexica	rigin? (Speci an, Puerto Ri	ity Yes or No- ican, etc.)		Race - Ameri Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 🕅 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 1 If Yes, Give Year or Dates:	_		1 🗆 Yes 2 🖸	No Specify	<i>r</i> :		Spe	acify: R1	ack
8	ture!	edt	15. Decedent	's Education		16a. Dece	dent's Usual C	ccupation			16b. Kind o	of Business/Ir	
215	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or	5+)	(Give	kind of work of DO NOT use i	lone during mo: etired)	st of working	7			
2	ed with	Com	12th			Solid	Dewate	ering O				ility	
ī	be file d of h	Be	17. Father's Name (First, Middle,							First, Middle, I Rachal	Maiden Sun	name)	
<u>~</u>	houid d Mer narke	ဥ	Ernest Doi	natto		10h Mailie	a Address /S	Rub			City or To	wn State 7	'n Code)
S S	ith an		Elaine Donatte				-	e Driv					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment if item 27 is marked other than "natural," or items 23a or 28a-f show may injury or other traumatic event, in Medical Examinat must be indiffed at another.		20a. Method of Disposition	_	20b. f	_l Place of Dispo cemetery, crei	sition (Name	of I	Da	te	20c. Locati	on - City or T	own, State
Ē	Page nent o nnt: If ury or		1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		'			Cem.	9/5/06	5	Annan	dale,	VA.
<u>a</u>	permit. Depertrimports Imports eny inju		21. Signature of Funeral Service	iceosee /	0			ddress of Faci				-	
_	20F 2	Ш	rulle 1	1-Cell	1		5538 Ma	rlboro	Pike	Fores		e, Md.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	line.				s cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	しっつ		ANCE	(_					
	Examiner			Due to (or as	s a consec	tuence of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consec	juence of):							
	outed	Examiner	Cause (Disease or injury that initiated events	С.									
760,	ate be executed hysicien and he burial-transit		resulting in death) Last	Due to (or a	s a consec	quence of):							
	cate b ohysic the b	dicai		d									
89 X	Attending Physician: The law requires thet the death certifica robath.  cloath. sctor: After this certificate has been signed by the ettending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregn	ancy	11-11-0-11-0-1				23d	Date of deliv	verv
P.O. Box	death etter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			Ectopic pregi Other (speci					Month	Day Year
o.	t the c by the	hys	9 Unknown	9□ Unknown									
s, T	es the gned be dei	by P	Part II. Other significant condition	ens contributing to death	but not res	sulting in the u	nderlying caus	e given in Part	: I.				the cause of death?
ord	w requir been si should	ted								1 Z Y	es 2□N	o 3∐Pro	bably 4 Unknown
ě	a law has b	Completed							<del></del>	24a. Was a autop:	sy	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
E E	r: The										2LX No		2 □ No
Ĕ	siciar certil irecto	o Be	25. Was case referred to medical examiner?  1 Tyes 2 XNo	Hospital: 1 Inpat	iont 2	ER/Outpatie	3 DOA	Othor		(Check only or e 5∭ Resid		Other (Spec	.6.1
<u>o</u>	g Phy er this eral d	<b> -</b>	27. Manner of Death	28a. Date of Inj	iury	28b. Time o		Injury at Work?		d. Describe h			ny)
lo	ath. rr: Ath	atio	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	gation	ay rear)	Injury	м	1 Yes 2	]No				
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 289. Place of Ir	njury - At h	ome, farm, st	reet, factory, o	ffice	28	If. Location (S City or Tow		umber or Rui	ral Route Number,
Ω	ospitai o hours af uneral D ly filled ir	Ce	4 7 0 0 1						1 .				
	T 4 T 0	edicai	29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical one)	g Physician: To the bes Examiner: On the basis and manners	of examina	ation and/or in	n occurred at ivestigation, in	my opinion, de	and place, areath occurred	d at the time, o	late and pla	ce, and due	stated. to the cause(s)
	within 2 yo the complet	Me	29b. Signature and title of certifie				29c. L	icense number	r	- 2	29d. Date si	gned (Month	, Day, Year)
	(n)		1 Ry Bu	u			0	01042	2071			08/31	100
	(2)		30. Name and address of passon		death (Ite	m 23a) (Type,	Print)					10	1
	J. C.	1	Roy Beveridge 31. Date filed (Month, Day, Year)	8503 Arling	ton B	oulevard	Suite	400 Fa	cirfox,	VA Z	2203		
	Sta Regist		SEP 0 1 2006	Ken 32. Hagis	uars sign	ature							
	3			AND A									

		-	For State Registrar		State of	Marylar			nt of H te of L		ind M	ental Hyç	giene Reg. No. 1	2006	5 2	28918
	Physicia	an	Decedent's Name (First, Mid	dle, Last)	Mom: E	D	avilin		-			2. Date of Dea Month	Day	Year	3. 1	Time of Death
	/Medic	al .	4a. Facility Name (If not institut	ion ake s		rances D	eviin	4h Cih	Town or	Location o	f Death	Septen		1, 2006 County of Dear		11:40 P. <sup>M</sup>
*	Examin	er	4a. Facility Name (if not instituti		llegany S			40. City	, TOWN, OF		nacon	ing.	40. 0	•	 legany	J
Sight.	Funeral Director		5. Social Security Number 219-14-6567	6. Sex			last birthday) Yrs.	If Unde Months	or 1 Year Days	If Under 2 Hours		8. Date of Birti (Month, Day February	h y, <i>Year)</i> 25 1023	9. Bir	thplace (	State or Foreign
256	A	-	Usual Residence of Decedent					ļ				Teordary	43, 174.			, , , , , , , , , , , , , , , , , , , ,
	how		10a. State 10b. Coun			10c. Ci	ty, Town or Lo	cation								side City Limits Yes 2 ☐ No
	8a-f	cto	Maryland	Alleg	any					onacon	ing,			4440		M 163 2 1140
	with ti	Funeral Director	10e. Street and Number	A llega	ny Street			101. 2	ip Code	21539	1		iog. Citiz	en of What Co US		
	na 23	erai	11. Marital Status		2. Was Deced	lent Ever in U	J.S. 13.	Was Dece	edent of Hi			cify Yes or No- Rican, etc.)	- 1	4. Race - Ame		dian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "netural", or itema 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ M 3 ▼Widowed 4 ☐ Divorc		Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	₹No		lf Yes, sp 1 ☐ Yes		n, Mexican Specify:	, Puerto I	Rićan, etc.)	1	Black, White Specify:	te, etc.	
ò	2 hou	ted	15. Deced	ent's Educ	ation		16a. Dece	dent's Us	ual Occupa	ation during most	of works	20	16b. Kin	d of Business	/Industry	
215	ithin 7	Completed	Elementary/Secondary (0-12		College (1-	4or 5+)	life.	DO NOT	use retired	)	Or WOTKI	·g		11	1	
21	filed withi Hygiene. other than		12		1					Home	r'o Namo	(First, Middle,	Maidan	Home	emake	er 
Maryland 21215-0036	2 should be fit and Mental H Is marked off aumatic ever	To Be	17. Father's Name (First, Middi		eter Stak	em				TO. IVIOUTE	i s ivallie		rtha O			
Man	nd 2 sho lth and I 27 Is ma r traume		19a. Informant's Name/Relatio				19b. Maili	ng Addres				I Route Numbe Frostburg,				<del>)</del> )
ē,	s 1 and 2 of Health Item 27 I		20a. Method of Disposition				Place of Dispo cemetery, crea	osition (Na	ame of other place	e)		ate eptember	20c. Loc	ation - City or	Town, S	State
E	Pages nent of h ant: If Ite		1 Burial 2 Crematio 4 Donation 5 Other		emoval from S	tate .	ocky Gap					6, 2006	F	lintstone,	, Mary	/land
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other 2008.	İ	21. Signature of Funeral Service	ce License	θ					s of Facility		al Home F	ο Δ 1	onaconi	na M	D 21530
Sec	Y F		23a. Part1. Enter the disease, shock, or heart failure. L	or samplic	cations that ca	used the dea	th. Do not en	ter the mo	ode of dyin	g, such as	cardiac o	r respiratory ar	rest,	Amacon	Appl	roximate rval Between
	Physician	Ü.	Immediate Cause (Final disease or condition	.o. oy o			tic a	den	0/4	rcina	mo	0100	19/4		-	et and Death
	/Medical Examiner		resulting in death)	( a	Due to (c	r as a consec	quence of):		0 2 31,	-1-1-						71
	Examine	l-	Sequentially list conditions	h.	Due to (e	r as a consec	augus of):									
	pet nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	0 01 888	1 43 4 0011300	4461106 017.									
,	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	¢	Due to (o	r as a consec	quence of):									
8760,	ysicie	dical		d												
9	rtifica ng ph r as th	Medi	IF FEMALE:													
Вох	The law requires that the death certifics ate has been signed by the effending pt page 2 should be detached for use as it.	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23		th 2 ☐Feta	aldeath 3[		pregnancy				2:	3d. Date of de Month	livery Day	Year
	the e	ysic	1 ☐ Yes 2 😿 No 9 ☐ Unknown		4∐Pregna 9☐ Unknov	int at time of o wn	death 5	Other (	specify)							
P.0	that the de ed by the detached		Part II. Other significant cond	itions con	tributing to dea	ath but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	obacco us	e contribute t	o the cau	use of death?
rds	quires f n signe	Completed by	Hypertense	en,	Hypo	thys	disn	1				101	Yes 2,	No 3□P	robably	4 Unknown
Ö	sw requir s been s should	piete	Dementia		7.							24a. Was		24b. Were a	utopsy fi	ndings available
æ	The lav	mo.										autor perfo	rmed?	death?	s 2	
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medi examiner?	cal							of Death	(Check only o				
∑f V	Physician: r this certific ral director,	2	1 ☐ Yes 2 MNo	Н	+		ER/Outpatie			7		me 5 Resid			ecify)	
n o	ding P h. After I funera	ion	27. Manner of Death 1 □Natural 5 □ Pen	ding	28a. Date of (Month)	i Injury n, Day Year)	28b. Time of Injury	M	28c. Injury Work	∤at k? Yes 2.∐l		28d. Describe I	now injury	occurred		
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	licat	3 Suicide 6 □ Cou	stigation Id not be	28e. Place	of Iniury - At h	nome, farm, st					28f. Location (	Street and	Number or R	ural Rou	ite Number.
Θį	s after s after al Dire	Certification:	4 Homicide	mined	buildin	g, etc. (Speci	ify)		,.			City or Tov	vn, State)			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (				sis of examin						and due to the ed at the time,				
	To th To th comp	Me	29b. Signature and title of cert	ifier	11	7 -			9c. License			1		signed (Mon	. , .	,
			1 (/h	mae	10	ever	nin E	9	02	1148	2.32		Sep	ot. 3	20	006
	2		30. Name and address of pers	on who	mpleted cause	of death (Ite	m 23a) (Type	Print)	1	/		oniwa	-1	/ /	1 _	
less.			31. Date filed (Month, Day, Ye	DeV.		D- LC ogistrar's Sign	Deagl	AS A	LVCAU	e, L	CAAC	coning	MA	yland	11-	357
	Sta Registi	-	SEP	- 6	2006	A Constitution of the Cons	A A	Ago.	80							

			1 - State Registrar	te of Maryland / Dep <i>Ce</i>	artment of Health an rtificate of Death	Re	3. No. 200	
	Physici /Medio	cal	Rose Paula  4a. Facility Name (If not institution, give street a	Dandy	4b. City, Town, or Location of D	2. Date of Death Month 9/2/06		4:58 P M
	Examir	lei	Dennett Road Manor		0akland		Garre	
İ	Funeral Director		5. Social Security Number 6. Sex 1 M 2!	7. Age (In yrs. last birthday, 97 Yrs.		Hrs. 8. Date of Birth (Month, Day, 4/8/19	9. Bi	rthplace (State or Foreign country) ennsylvania
	death with the Maryland ms 23a or 28a-f show Fittual be notified at	J.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	rect	MD Garrett  10e. Street and Number	1	Oakland  10f. Zip Code	10	g. Citizen of What C	
	h with 23a or	ai Di	4167 Maryland Highway		21550		USA	A
20	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural; or Itams 23s or 28s-1 show event, the Mariteal Examinat must be notified at	y Funerai Director	1 Never Married 2 Married 1 If Y	Yes 2 XNo es, Give	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 🛣 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
ş	tural;	ed by	3 Widowed 4 □ Divorced Yes	r or Dates:	dent's Usual Occupation	1 1	6b. Kind of Busines	
21215-0036	be filed within 72 hours after stat Hygiene. Ind other than "natural", or Ita event, the Medical Examira	ompieted	(Specify only highest grade comp	ege (1-4or 5+) (Give life.	kind of work done during most of DO NOT use retired) Othes Presser	working	Clothi	·
ם פ	e filed of Hygis other vent, I	O	17. Father's Name (First, Middle, Last)			Name (First, Middle, M		
ryland	2 should be and Mental is marked reumatic ev	ToB	John Fa  19a. Informant's Name/Relationship (Type, Prince)	rinetti 19b. Mail	Pasqu		City or Town, State.	Tedesco
Mar	nd 2 salth an 27 is		Ivan Rowe/ Son		Maryland Hwy,		•	
Baitimore,	ages 1 a ant of Hea it: If item y or othe		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ Remova  ↑ 4 □ Donation 5 □ Other (Specify)	from State Glen Have	matory or other place)		oc. Location - City o	
Balt	permit. Pages 1 and 2 should by Department of Health and Menta importent: If item 27 is marked any injury or other treumatic angone.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility  32 S. Second St	Stewart Fun	neral Home	2
	Physician		23a. Part1. Enter the usease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the death. Do not ene on each line.				Approximate Interval Between Onset and Death minutes
	/Medical Examiner			ue to (or as a consequence of):				
,097	ate be executed hysician and the burial-transit	cai Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.	ue to (or as a consequence of): ue to (or as a consequence of):				
O. Box 68	ath certific attending pl for use as t	hysician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year
ras, r	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributin	g to death but not resulting in the u	inderlying cause given in Part I.		37	to the cause of death?  Probably 4 Unknown
I Kecords,	The lar ate has page 2	Completed	L			24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
VItal	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?			Death (Check only one		
ō	Phys this ral di	lon: To		1 ☐ Inpatient 2 ☐ ER/Outpatie  Date of Injury (Month, Day Year)  28b. Time of Injury	of 28c. Injury at Work?	ng Home 5 Resider 28d. Describe how		ecify)
DIVISION	or Atten ifter deat Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
	Hospita 4 hours Funeral ely fillec	edicai C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, dea the basis of examination and/or in d manner stated.	th occurred at the time, date and privestigation, in my opinion, death of	lace, and due to the cat occurred at the time, dat	use(s) and manner a e and place, and du	as stated. te to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	200	29c. License number		d. Date signed (Mor	oth, Day, Year)
	2		30 Name and address of person who complete	d cause of death (Item 23a) (Type		Acr D	v Oak	M hu
	Sta Regist		31. Date filed (Month, Day, Year)  SEP - 5 2006	32. Registrar's Signature	Acollo	. 10.7	. 0-00	2126

		-	For State Registrar		State o	f Maryla		artmen rtificate		ealth and M Death		giene Reg. No. 2	006	28920
	Physicia	an	1. Decedent's Name (Firs Gaetan De		ast)						2. Date of De Month AUG.	Day	Year 200 C	3. Time of Death
	/Medic Examin		4a. Facility Name (If not in	1	./	mber)	no les	4b. City,	Town, or	Location of Death	1140	4c. County		•
	Funeral		5. Social Security Number	19/10/14 6.	Sex 1X M 2□ F	7. Age (In yr.	s. last birthday)	If Under		If Under 20 Hirs.	8. Date of Bir		9. Birthpl	ace (State or Foreign
	Director		063-30-9309 Usual Residence of Dece		1 <b>X</b> M 2□ F	68	Yrs.	Months	Days	Hours Min.	107317	1937	Coun	NY
	yland			County			City, Town or Lo	ocation					10	Od. Inside City Limits
	he Mar	ector	MD W  10e. Street and Number	orces	ter	Be	rlin	10f. Zip	Codo			10a Citizan of I	Mhat Caus	1 ☐ Yes 2 🌠 No
^	h with 1	E Dir	135 High S	herif	f Trail			218				10g. Citizen of 1	what Coun	uyr
19-009 036	within 72 hours after death with the Maryland ane. "neturel", or items 23e or 28s-f show then "neturel", or items 23e or 28s-f show he Madicel Examitter must be notified at	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 47.70		Armed Fo	2∭No ve		Was Deced If Yes, spec		spanic Origin? (Spon, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - Americ ck, White, c y.White	etc.
5-0036	72 ho	eted	15. E (Specify on	Decedent's ly highest g	Education rade completed)		16a. Dece (Give	dent's Usua kind of wor	l Occupa k done d	ition luring most of work	ing	16b. Kind of B	usiness/Ind	lustry
821212	d within liene. r then	ошр	Elementary/Secondary	(0-12)	College (	1-4or 5+)		e Off				Law En	forcer	ment
3 pm	nit. Pages 1 end 2 should be filed within artment of Health and Mental Hyglene. ortant: If Item 27 is marked other then injury or other treumatic event, the M. E.	BeC	17. Father's Name (First,		st)		,			18. Mother's Name			ne)	
C. Z.	should be nd Mental marked o	၉	Gus DeMar  19a. Informant's Name/P		(Type, Print)		19b. Maili	ng Address	(Street a	Gilda Gund Number or Rura			State, Zip	Code)
Mag.	end 2 ealth ar n 27 ts		Robin Dean							ff Trail		-		
DEMARCO (  Baltimore,	nt of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 4 ☐ Donation ★ X		Removal from	State 20b	Place of Dispo	nsition (Nan matory or o	ne of ther place	9)   00 (20	Date /2006	20c. Location	•	
altin	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral			illerie 9				08/29, s of <sup>Facility</sup> Burl		Bishop neral H		, ויוט
13C	88 5 8		23a. P. rt1. Enter the shock, or heart falls	1	mond		10	R MII	11am	Street	serlin,	MD 218.	11	Approximate Interval Between
9	Physician /Medical Examiner	Examiner	Immediate Cause (in al disease or condition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	1	a. Due to	reta	equence of):	Paid	here	l Cele	l Ca	ncec		Onset and Death
O. Box 68760,	ysicie	Physician/Medical Ex	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 \[ \text{Yes} \ 2 \] No 9 \[ \] Unknown			tcome of preg pirth 2 □ Fe	ital death 3	⊒Ectopic pr ⊒ Other (sp					ite of delive	ry Day Year
ds, P.O	uires thet t signed by Id be deta	Ď	Part II. Other significant	conditions	contributing to d	leath but not re	esulting in the u	inderlying c	ause give	n in Part I.		obacco use con		e cause of death?
Division of Vital Records,	iician: The law requir certificete has been si rector, page 2 should	Completed									24a. Was auto perfo 1 \( \text{Yes} \)	psy prmed?	Were autop prior to con death? 1  Yes	psy findings available inpletion of cause of
Z ×	ysician: ils certific director,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medical	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3□ DO	A Othe	26. Place of Death			ner (Specify	·)
o u	g		27. Manner of Death t Natural 5	Pending		of Injury oth, Day Year)	28b. Time o Injury		Bc. Injury Work	at		how injury occur		
Divisio	Atten or dest ector; by the	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigati Could not determine	be 28e. Place	e of Injury - At ing, etc. (Spe	home, farm, sti	M reet, factory		fes 2 □ No	28f. Location ( City or To	Street and Numb wn, State)	ber or Rura	l Route Number,
	To the Hospitel or within 24 hours effe To the Funerel Dir completely filled in	edical	29a. Certifier 179 (Check only one)	Certifying I Medical Ex	aminer: On the b	e best of my k pasis of exami nner stated.	nowledge, deat nation and/or in	h occurred ivestigation	at the tim in my op	e, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of	of certifier		-	) # (	2		number	10	29d. Date signe	ed (Month, l	Day, Year)
£	45		30. Name and address of	. 1		ARROLL	em 23a) (Type,	Print)	411.	Md. 21	8171			
	Sta Registr		31. Date filed (Month, Da		32. F	Redistrar's Sig	nature	-	,	······································	5 67 7			

			1 = For State Registrar	State of Ma			nent of He cate of L		d Mental H	ygien	2006	28921
			Decedent's Name (First, Middle, L	ast)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2. Date of I	Death	ay Year	3. Time of Death
E	Physici /Medic		John Owen	Edgar					Augu	st 3,	2006	3:02 A M
	Examin	er	4a. Facility Name (If not institution, grant 213 Teaberry La			4b.	City, Town, or	Location of De ident	eath	40	c. County of Dea Garre	
-	Funeral		-	Sex 7. Ag	e (In yrs. last birtl		Inder 1 Year	If Under 24 h	drs. 8. Date of I	Birth Day, Year		rthplace (State or Foreign ountry)
	Director		217-30-1659	1 <b>X</b> M 2□F	74 Y	Yrs. Mor	nths Days	Hours M	Feb.	23, 1	932 Mar	yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	1					10d. Inside City Limits
	Mary a-f eh	tor	MD Gar	rett		Acci	dent					1 ☐ Yes 2 📉 No
	ith the	Director	10e. Street and Number			10	f. Zip Code			10g. C	itizen of What C	-
	eath v		213 Teaberry Lan	.e 12. Was Decedent	Ever in 11 S	13 Was F		1520	(Specify Ves or	Yo- 1	USA 14. Race - Am	
980	within 72 hours after death with the Maryland jiene. rithen "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 X Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 1  If Yes, Give Year or Dates:	No		specify Cubar	Specify:	(Specify Yes or liverto Rican, etc.)	10"	Black, Wh	
Maryland 21215-0036	72 ho 'natur	Completed	15. Decedent's I (Specify only highest g		16a.	(Give kind	Usual Occupa of work done d	uring most of	working	16b. i	Kind of Busines	s/Industry
121	within ene. then "	ldmo	Elementary/Secondary (0-12)	College (1-4or		life. DO N	OT use retired) k Drive	)		C	* o = 0 · ·	
d 2	를 수 를 된 의 수 를 된	Be Co	17. Father's Name (First, Middle, Las	t)		Truc			Name (First, Midd		tone Qu n Sumame)	arry
/lan	9 5 5 5	To B	John William	Edgar				Sad	lie I	ranc	es	Sloan
Man	C1 (0 (8	1 3	19a. Informant's Name/Relationship		1.				Rural Route Nur			Zip Code)
	s 1 and 2 if Health item 27 other tra		Elizabeth Edgar/ 20a. Method of Disposition	wire	20b. Place of	Disposition	(Name of	-	Accident Date		ryland -ocation - City o	21520 r Town, State
ā	Pages nent of I int: if it		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Omega	y, crematory	or other place		5/06		rgantow	
Baltimore,	permit. Pages Department of I Important: if ite eny injury or of		21. Signature of Funeral Service Lid	1	1 8	22. Nan	ne and Address	s of Facility	•	. Se	cond St	
	Parks Parks		23a. Part1. Enter the disease, or conshock, or heart failure. List ont	nplications that caused y one cause on each li	the death. Do no	1						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	hysema a consequence o	of).						Years
, Keri	Examiner		Conventially list and dising	h	a 001100qu011000	,,,						
	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as	a consequence o	of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	of);	_					
58760,	e be e rsiciar e buri	dicalE		d								
			IF FEMALE.									
Box	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnani at	2 Fetal death		oic pregnancy or (specify)				23d. Date of de Month	olivery Day Year
P.0	at the de f by the a stached	Phys	9 Unknown	9□ Unknown								
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underly	ing cause give	n in Part I.				o the cause of death?
Vital Records,	The ate h page	Completed					<u>.                                    </u>		ре	is an lopsy formed? 2 \(\sum \) No	death?	utopsy findings available completion of cause of
Vita	Physician: this certificinal director,	Be	25. Was case referred to medical examiner?	Hospital:			Otho		Death Check onl			
o	Phys r this ral dir		1 ☐ Yes 2 🛣 No  27. Manner of Death	1 🔲 Inpatie	ent 2 EP/Out		DOA Othe	4 🗀 14012111	g Home 5X Re			ecify)
ion	Attending Fr death. actor: After by the funer	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) In	ijury M	28c. Injury Work 1 🗆 Y	? ′es 2 □ No			,	
Division	al or Atter after des i Director d in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, far c. (Specify)	rm, streel, fa	actory, office		28f. Location City or 7	(Street a own, Stat	nd Number or F e)	lural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: /	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis o and manner st	l examination and	, death occu	irred at the time ation, in my op	e, date and pla inion, death or	ace, and due to the	e cause(s	s) and manner and place, and du	s stated. e to the cause(s)
	To the within 2. To the I complet	X	29b. Signature and title of certifier				29c. License				ate signed (Mon	th, Day, Year)
			18/				Ι	)23979		8	/4/06	
_	1		30. Name and address of person who Dr. Robert Gorla		eath (Item 23a) (1 311 N. F		St., 0	akland	, Maryl	and	21550	
10	Sta Registr		31. Date filed (Month, Day, Year) AUG = 7	2004	ar's Signature	A STATE OF THE STA	365 5					

			For State Registrar		Marylan	d / Depa	artment of H	lealth ai Death		Reg	ene No. 200	16 2	8922
	Physici	_	1. Decedent's Name (First, Middle, La Lorraine Elizat		erer					Date of Death Month ugust 1		ear	ne of Death
	/Medic Examin		4a. Facility Name (If not institution, giv		er)		4b. City, Town, or		Death	ugust 1	4c. County of	Death	
			Holy Cross Hospi  5. Social Security Number 6.5		Age (In yrs. I	la et hirthday)	If Under 1 Year	r Spri		Date of Birth		ntgomery	
Е	Funeral Director		,	I M 2 1 ★F		9 Yrs.	Months Days	Hours	Min.	Month, Day, You 1y 27,	ear)	Country) Chicago	
	and *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d Insid	le City Limits
	f aho	5	215										Yes 2 XNo
	28a-	Director	Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code							10g	. Citizen of Wh	at Country?	
	3a oi	<u>i</u>	9101 Sligo Creek	Parkway				20901			US	SA	
	deat	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origi	in? (Specify	Yes or No-		American India White, etc.	n,
36	72 hours after death with the Maryland natural', or itema 23a or 28a-f ahow diesi Examinar must be notified at	by Fu	1 ☐ Never Married 2 ₹ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give	⊠ No		1 ☐ Yes 2 ☒ No		, 40110 1 1100	, 0.0.,	Specif W		
9	P hour	ed t	15. Decedent's E	Year or Date	15.	16a. Deced	lent's Usual Occupa	ation		16	b. Kind of Busin	ness/Industry	
215	hin 7%	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4	or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most o	of working			,	
21	od with	Com	12	College (14	01 347	Hom	emaker					Own Hor	ne
Maryland 21215-0036	be fits Hy of h	Be	17. Father's Name (First, Middle, Last								iden Sumame)		
7 3	d Mer narke natic	ဥ	William Joseph 1  19a. Informant's Name/Relationship (			10h Mailie	ng Address (Street a			roline		7-0-4-1	
Ma	th an		Leonard A.C. Eise		band	1					•		00001
	f Hee		20a. Method of Disposition	•	20b. P	lace of Dispo	Slijo Cr sition (Name of natory or other place		Date			by or Town, Stat	
Ë	Page nent o nt: If		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		110		ven Cemeter	I A	ugust 2006		dilwar 9	Spring N	Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 Is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examinar must be notified at once.		21. Signature of Funeral Service Licer	nsee Qu		F <del>2</del>	ancers Agres O Univers	scoring Sity B	ns Fu	neral H	ome Inc		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	ed the death	n. Do not ente	er the mode of dyin	g, such as ca	ardiac or res	spiratory arrest	,	Approx	imate I Between
	Physician		Immediate Cause (Final disease or condition	a Stroke								Onset a	and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
	* *	er	Sequentially list conditions, a sequentially list conditions, and any, leading to immediate the sequentially list conditions.										
	uted d ansit	Examiner	cause, (Disease or injury										
oʻ	e exectian an		resulting in death) Last	c. Due to (or	as a consequ	uence of):							
8760,	deeth certificate be executed e attending physician and of for use as the burial-transit	dica		_ d.			_						
9	eeth certific attending p	/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ncv					and Date of	d dalian.	
Вох	d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth	n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of Month		Year
Ö.		hys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Demont is Plause Teffusion										
rds, P	w requires thet the been signed by the should be detache	þ										ite to the cause	
of Vital Records,	e law hes b	Completed							_	24a. Was an autopsy performed	pric	re autopsy findi r to completion th?	ngs available of cause of
tal		a)	25. Was case referred to medical					ac Bloom		1  Yes 2 ₹		Yes 2□ No	
<u> </u>	iysician: iis certifica director,	To B	examiner? 1 ☐ Yes 2. ₹ No	Hospital:	atient 2 1	ER/Outpatien	t 3 DOA Othe				e 6 Other	(Specify)	
ion of	ding Ph n. After th funeral		27. Manner of Death  1. CNatural 5 Pending 2 Accident investigatio	28a. Date of I (Month,		28b. Time of Injury	28c. Injury Work		28d.		injury occurred		
Division	ital or Attendrices effer deathal Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined				eet and Number or Rural Route Number, State)						
	Hoap 4 hou Funer	edicai	29a. Certifier (Check Only one)  (Check Only one)	nysician: To the be miner: On the basi and manner	s of examinat	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and pinion, death	place, and o occurred a	due to the caus t the time, date	e(s) and mann and place, and	er as stated. I due to the cau	se(s)
	rothe Z	ž	29b. Signature and title of certifier	n / n	~ D		29c. License	number		29d.	Date signed (/	Month, Day, Yea	ir)
)	15		Ksham					0826		A	ugust 1	8, 2006	,
				1500 For	est Gl	en Roa	d, Silver	Spri	ng, M	20910			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 20	306 32 Reg	istrar's Signat	April 1	de						

			1 = For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of H	lealth and I <i>Death</i>	Mental Hygi	ene g. No. 2006	28923
1	Physici	an	Decedent's Name (First, Middle, Last)	Howard EISEN				2. Date of Death		3. Time of Death 3:32 A M
	/Medic Examin		4a. Facility Name (If not institution, give str 13712 Castle Cliff	eet and number)			r Location of Death		4c. County of Deat	th
	Funeral Director		5. Social Security Number 6. Sex 15-44-5070 158	7. Age (In yrs. 59	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept 11	Year 1946 Was	thplace (State or Foreign
	<u>D</u>		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	ecation				10d. Inside City Limits
	Maryla f show	ō	Maryland Montgomer			r Spring				1 ☐Yes 2 XNo
death with the Maryland	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code	0/		g. Citizen of What Co	
	23a	ral [	13712 Castle Cliff	. Was Decedent Ever in U	S 12	209			nited Stat	
	be filed within 72 hours after death with the Marylar list Hygiene. Id other then "natural", or iteme 23s or 28s-f show event, the Medical Exammer interpretation	by Fune	11. Marital Status 12  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 ♥ Yes 2 □ No If Yes, Give Year or Dates: Viet		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	Black, White	e, etc.
5	72 hou natura ilgal E	eted	15. Decedent's Educa (Specify only highest grade	ition	16a. Decadent's Usual Occupation (Give kind of work done during most of w			rking 1	Industry	
7	within no.	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)					n 11 n	1.0
70	e filed with It Hygiene.		17. Father's Name (First, Middle, Last)	2		tive Vic	18. Mother's Nar	ne (First, Middle, M	Ronald Pau Maiden Sumame)	II Company
land	should be and Mental marked o	To Be	Ι	David Trudeau	ı Eisen	L	Sylvia	a Novey		
Jan	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic events.	i	19a. Informant's Name/Relationship (Type		1				City or Town, State, 2	
e,	1 and Health tem 27		Patricia Eisen, Wif			sition (Name of matory or other place			Spring, M. Oc. Location - City or	
	Pages nent of int: If it		1√2 Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval nom State		matory or other place emorial G		·	Olney, MD	
all	permit. Departmine importa eny inju		21. Signature of Fun in Penior Licensee		22	. Name and Addre	ss of Facility	Funeral H		
u	405 a		23a. Part1. Enter the disease, or complication	ations that caused the deal	-	-				20012 Approximate
Physic /Med	Di catalan		shock, or heart failure. List only one	cause on each line.  Gastric Car					51,	interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec						
	Examiner		Sequentially list conditions, b.	Due to (or as a consec						
	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
<b>5</b>	be executed sicien and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consec	juence of):					
9/90	icate be ex physicien s the buria	dicai	d.		<del></del>					
٥	death certificate e attending phys d for use as the		IF FEMALE: 23	c. If yes, outcome of pregna	ancy			300	23d. Date of de	livery
žog.	death e atter rd for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta		Ectopic pregnancy Other (specify) _	/		Month	Day Year
5	t the	Phys	9 Unknown	9∐ Unknown				One Bitter		the course of death?
ds,	w requires that been signed b should be deta	δ	Part II. Other significant conditions conti	nbuting to death but not res	suiting in the u	nderlying cause giv	ren in Paπ I.	1 ☐ Ye	acco use contribute to s 2-⊋No 3□Pr	robably 4 Unknown
Cord		Completed						24a. Was an	24b. Were au	utopsy findings available
He	The ate h page	mo						autopsy perform 1 Tes 2	ed? death?	completion of cause of 2 □ No
Vital	sician: certific irector,	Be	25. Was case referred to medical examiner?	spital:		ott	oc	ath (Check only one		
ō	Phys r this o	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	IL 3LI DOA	4   Nursing r	lome 5 X Resider 28d. Describe how	nce 6 Other (Spe winjury occurred	cify)
0	ath. r: After t	ation	1 Accident 5 ☐ Pending investigation	(Month, Day Year)	Injury	M 1 🗆	rk?  Yes 2∐No			
DIVISION	al or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, office		28f. Location (Str City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai (	29a. Certifier 1 X Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my knose: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	a, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the vithin To the comp	×	29b. Signature and title of certifier	1, (00)	me	29c. Licens		- 1	d. Date signed (Mgnt	h, Day, Year)
,	10+1		Brune V	N			6461	7	8/25/0	6
	•		30. Name and address of person who con Geneieve Wroblewsk				. #100. F	Rockville	MD 20850	
	Sta		31. Date filed (Month, Day, Year)	32. Segistrar's Sign	ature	selle	,			
	Regist	rar	AUG 28 20	06 Johns	15. 10					

06-06386		Please Type or Print in Black Indelible Ink			
Steven Charles F		State of Maryland / Department of Health and Mental Hy	ygiene	200	c 2002
	ل	1- For State  Registrar  1. Decedent's Name (First, Middle,Last)	Re 2. Date of Death	g. No. 200	6 2892 3. Time of Death
Physicia Medical Examin	117	Steven Charles Furr		Day Year	0848 hrs
Para		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
		I-70 at Harmony Road Frederick		Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min		h(MM/DD/YYYY) 9. Birt Foreig	n
Director	Į	2/2-56-/306 1 XM 2 F 51 Yrs.	March	25, 195 <b>5</b> co	untry) Ohio
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
*		Maryland Montgomery Damascus			1 Yes 2 X No
arylar	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
the M		25740 Ridge Road 20872		U.S.	Α.
death with the Mayland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St		14. Race - Americ White, etc.	can Indian, 8lack,
or ite	Fun	1 Yes 2 X No		Specify: Whi	te
ural",	ā	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vice in the complete of the complet		16b. Kind of Business/li	ndustry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retr	red)	00.1	1
036 ithin and serventer than	g	2 Operations		Computer	
215-0036 be filed within 7 ntal Hygiene rked other thau ent, the Medica		17. Father's Name (First, Middle, Last)  Charles William Furr  Virgin	e (First, Middle, M nia Lit		
2121 2121 wuld be f Mental marke	o Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I			Zip Code)
MD 2 nd 2 shou alth and N m 27 is n	٩	Karen E. Furr - Wife 25740 Ridge Road, I			20872
e, N l and 2 Health item 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
nor ages ent of nt: If			ot. 1, 0	6 Damascus	, Maryland
Baltimore, MD 21215-0036  permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other thau "uatural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be natified at once		21. ignature if Funeral Service Licensee 22. Name and Address of Facility  110 Les Worth — William	ns P.A	Funeral Ho	one —
		Rovert L. Allum 126401 Ridge Road.	Damascu	s. Maryland	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	est, snock, or reart	8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Multiple Injuries  Due to (or as a consequence of):			Death
1.		Sequentially list conditions, b			
	aminer	if any, leading to immediate Due to (or as a consequence of):			
	cam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transi	cal Ex	d			
), be exe sician a		UNPENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery  Month	y Day Year
x 68 th certification truse a	icial	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
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on ending ath.	tion	1 Natural 5 Pending Aug 26, 2006 0839 hrs 1 Yes 2 No	Driver auto a	auto collision and	ejected
Visi or Att fiter de Direct in by	ifice	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Ru	ral Route Number, City
Division of Vital Rec optral or Attending Physician: The ours affer death. Filled in by the funeral director, page	Certification:	4 Homicide determined (Specify) Interstate/Express		nony Road, Freder	ick, MD
To the Hos within 24 h To the Fun completely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To th withi To th	Medical	29b. Shanture and title of certifier  29c. License number		29d. Date signed (Mo.	
	-	United States of the Contract		August 27, 2006	
10		30 Name and address of person who completed cause of death (Item 23a)			
- 10	į.	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
S	tate	31. Date filed (MontADIGY 2019 2006 32. Faistrar's Signature			
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	Sta Registi	te ar

State of Maryland / Department of Health and Mental Hygiene 2006 28925 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 26, AUGUST 2006 3:45A CHARLES BURTON GARNETT /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES FORESTVILLE NURSING & REHABILITATION FORESTVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG. 20, 1 9. Birthplace (State or Foreign Days Hours 1**X**XM 2□ F KÄNSAS 331 14 3344 85 Ĩ921 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MYes 2 □ No PRINCE GEORGES SUITLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4914 PARK LANE SOUTH 20746-1272 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married XXMarried 1 ☐ Yes 2XXNo Specify: Specify: WHITE by 3 Widowed 4 Divorced or than "natural;, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AIR FORCE PILOT/WRITER-EDITOR U.S. AIR FORCE 4 YRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental I nt: if item 27 ie marked ot y or other traument ELEANOR VINCENT BASIL GARNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, KATHARINE M. GARNETT / WIFE 4914 PARK LANE SOUTH SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 08/30/2006 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22 Name and Address of Fruheral HOME OF MARYLAND, INC. Haus 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY FAILURE Due to (or as a consequence of) RESPIRATORY FAILURE Sequentially list conditions Due to (or as a consequence of) Examiner I any, leading to immedicause. Enter Underlying Cause (Disease or injury physician and s the burial-trans ASPIRATION PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical DYSPHAGIA attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X X Unknown PARKISON'S DISEASE, HYPERTENSION, DEMENTIA ted been Complete 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) Was a autopsy performed? 24a. Was an page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: XX Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ation: XX Natural 5 Pending Infury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) itle o certifie 29b. Signature and D51520 AUGUST 29, 2006 30. Name and address of person who completed cause o death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE, SE #310 WASHINGTON, DC 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature

-acobo Aloy Godu 06-06212

Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2006 28926 1. For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Month Day August 19, 2006 Medical Examine 1715 hrs Jacobo Alay 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Route 15 @ Route 464 Point of Rocks Frederick 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Guatemala Months Days Hours Director 35 1 X M 2 F 2-02-1971 None Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 Yes 2 X No VA Fairfax Centreville death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 14817 Slethwick Place 20120 Guatemala Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Guatemalan Caucasian Specify Guatemali f Yes, Give Year 1 X Yes 2 No Widowed Divorced specifHispan: 'natural", ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical Farmer Baltimore, MD 21215-0036 Faremr Farming ies I and 2 should be filed withit of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mergerito Slay Lopez Marta Godoy Pingda 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Berrera -Uncle 10624 Winfield Loop, Manassas, Va. 20141 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State permit. Pages 1 Department of F 1 XBurial 2 Cremation 3 X Removal from State crematory or other place) Important: injury or oth 08-27-06 Progresso, Guatemala Progresso Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8521 Sudley Rd., Manassas, Va. 20109 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Part I Enter the **Physician** Approximate Interval failure. List only one cause on each line. Retween Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed and Physician/Medical UNPENDED #16aperFH8/28/06,BMW,MoCo 14perFH8/28/06 BMW MaCa Division of Vital Records, P.O. Box 68760, attending phys for use as the bu IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other4 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 2Ba. Date of Injury (Month, Day Year) Aug 19, 2006 27 Manner of Death 2Bb. Time of Injury 2Bc. Injury at Work 2Bd. Describe how injury occurred Certification: Ejected occupant auto auto collision Natural 1710 hrs Pending Yes 2 V No To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 2Bf. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Rt 15 @ Rt 464, Point of Rocks, MD determined (Specify) Major Road / Highway Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) mio O.C.M.E. August 20, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ling Li, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (MONT) State

Registrar

2006

	1	For State Registrar		Cer	tificate	of	Death			2032
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		ALICE THERESA HODGES							27, 200	6 7:20P N
		a. Facility Name (If not institution, give street and	number)		4b. City, T	own, o	r Location of Death		4c. County of De	ath
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by Fig.	2	1 Never Married 2 Married 1 Yes	es 2.XXIII Give				Specify:	Hican, etc.)		nite, etc. BLACK
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T B C	ם ב	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 27. Manner of Death 28a. D		ER/Outpatien 28b. Time of fnjury		Oth c. Injur Wor	er: 4 🗆 Nursing Ho	me 5□ Resi		
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	edica edica	Physician/Medical Examiner  To Be Completed by Funeral Director	State Registrar	1. Decedent's Name (First, Middle, Last)	1. Decedent's Name (First, Middle, Last)	1 - State   1. Decedent's Name (First, Middle, Last)   ALICE THERESA HODGES	1 - State registrar   Certificate of	Stellar   Decoderits Name (First, Middle, Last)   ALICE THERESA HODGES	1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   1 - Stellage   2 -	1 - State   1 - Decedent's Name (First, Mickele, Last)   2 - Cant of Death   3 - County   4 - Chy, Town, or Location of Death   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, or Location   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, Town, State, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4 - Chy, State   4

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10

State

Box 68760

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32. Raistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chaus Chai 2001 Madical PKWy

AUG 2 5 2006

Chang Choi

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2006 28929 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $P^{M}$ 27 2006 4:30 August Haines Dorothy /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Mount Airy Kline Hospice House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs 78 June 21, 1928 Pennsylvania 162-22-3176 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1⊠Yes 2 No Frederick Maryland Frederick Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21701 United States 508 Culler Avenue death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☒ No Specify White Specify: þ 3 ☐ Widowed 4 🕅 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. Homemaker Own Home 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Itam 27 is marked oth any liury or other traumatic event ange. Be Frank Thomas Laura Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Amwell Road Hillsborough, New Jersey 08844 Charlotte Anderson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition August 29, Frederick, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the diskase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DPD IDYRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical signed by the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time ot death 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TACHYCARDIA 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 2 No 1 Yes director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No I hours after death.

unaral Director: A
sly filled in by the fu investigation death. 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number A) milion 8/23/2006 321936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK 21702 くってもなると 656 THOMAN DONELSON, ALD 31. Date filed (Month, Day, Year) AUG 2 9 2006 egistrar's Signature 32. State Registrar

			1 - For State Registrar	State of M	/larylar		artment					giene 1eg. No.2	006	28930
			Decedent's Name (First, Middle, Last	")						-	2. Date of Dea	ith	000	3. Time of Death
П	Physici		Lawrence H.	Han1i	n						Month August	Day 31	2006	6:20 p <sup>M</sup>
1	/Medio Examir		4a. Facility Name (If not institution, give				4b. City, 1	Fown, or	Location of	of Death	1148444		unty of Death	1 0:20 p
		•	Dennett Road Mand	or Nursin	e Hon	ne	0a	k1ar	nd			Gan	rrett	
	Funeral		5. Social Security Number 6. Se	x 7. A		last birthday)	If Under			24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
	Director		232-09-3257	ZM 2□F   {	39	Yrs.	MOIBS	Days	riours	IVIII I.	Jan. 8			
Т	pu s		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation							10d. Inside City Limits
	shor anyle	ក	Too. County											1 Yes 2 □ No
	he N	Director	MD Garrett	<u>:</u>	l F	(itzmil	ler 10f. Zip (	Codo			1.	IO- Citi	of What Cou	
	with a or			_										,
	eath	era	W. Main Street	12. Was Deceden	t Ever in II	S 13 1	1	538	nanic Orie	nin? (Sne	oifu Vas or No		ed Stat Race-Americ	
36	be illed within 72 hours after death with the Maryland ital Hygiene. In the matural, or items 23s or 28s-1 show svent, the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give	? No		f Yes, speci		Specify:	, Puerto	ecify <b>Yes</b> or No- Rican, etc.)		Black, White,	etc.
8	hour fural	효	1	Year or Dates		160 Dogg	tooto I laval	000000	ation .			10h Kind	Whit	
5	n 72	Completed	15. Decedent's Edu (Specify only highest grad			(Give	tent's Usual kind of work DO NOT use	k done d	urina most	t of worki	ng	160, Kind (	of Business/In	dustry
12	withi ene.	ᄩ	Elementary/Secondary (0-12)	College (1-4or	5+)		ker					rai	lroad	
9	filed Hygi ther	ပိ	17. Father's Name (First, Middle, Last)			WOL	RCI		18. Mothe	r's Name	(First, Middle,			
an	Mental Mental arked o	To B	James Hanlir	1					Net	tie	W-	ilson		
2	g p E E	۱	19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address	(Street a			l Route Numbe		wn. State. Zic	Code)
$\mathbf{z}$	or = =		Frances Hanlin, V			1		•			tzmille:		21538	
ē,	tem tem oths		20a. Method of Disposition	VIIC	20b. F	Place of Dispo	sition (Name	e of	1				on - City or To	
9	M O		1 Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		9	emetery, cier albaugh			· I	9/3/	06	Flk (	Garden,	1.777
Baltimore, Maryland 21215-0036	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Licens		IX				- 1					al Home
B	permit. Departr Importe eny Init		MANAGE Y	Bunda	ch									ar nome , MD 21538
			23a. Part1. Enter the disease, or complete	lications that cause	ed the deat	h. Do not ent	er the mode	of dying					ZIIITTTEI	Approximate Interval Between
	1		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each	line.									Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due o (or a	s a consen	MON	110						-	luce K
	Examiner			7/2/s	100	p d	don	a 0	1	4			1	1011101C
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseq	uence of):	LLW	u	0110					year >
	uted d ansit	튵	Cause (Disease or injury that initiated events	_										•
Ċ.	exec in an	Exami	resulting in death) Last	Due to (or a	s a conseq	uence of):								
8760,	icate be executed physician and s the burlai-transit	dicai		đ										
မှ	tificat og ph es th	Ped												
Вох	that the death certifii ed by the attending I detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Estania ora					23d.	Date of delive	ery
	deatl e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Ectopic pre Other (spe						Month	Day Year
P. O.	t the by th ache	hys	9 ☐ Unknown	9□ Unknown							7			
ď.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use es	by P	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use o	contribute to th	ne cause of death?
ë	w require been sk should b	ed l	Mypertensin	2/V							1 🗆 Ye	s 2DN	o 3 ☐ Prob	ably 4 Unknown
Records,	law re as bea 2 sho	plet	•								24a. Was a		4b. Were auto	psy findings available
ď	The lay	Completed									autops perform	ned?	death?	impletion of cause of
Vital	diffice	Bec	25. Was case referred to medical	<del></del>					26. Place	of Death	(Check only on			
$\geq$	ysici is ce direc	ToB	examiner? 1 Yes 2 Ho	lospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatien	t 3 DOA	Othe			ne 5∐Reside		Other (Specifi	<b>(</b> )
0	Attending Physician: r death. sctor: After this certification in the funeral director, in		27. Manner of Death	28a Date of Inj	ury av Year)	28b. Time of Injury	28	c. Injury Work		-	8d. Describe ho			
ō	Attendir death. ctor: Af y the fur	atic	1 □ Natural 5 □ Pending 2 □ Accident investigation	,	, , , , ,	,,	М		es 2⊡N	No				
Division of	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	njury - At ho tc. <i>(Specif</i>	ome, farm, str	et, factory,	office		2	8f. Location (St City or Town	reet and No	umber or Rura	l Route Number,
	tal or A rs after af Dire ed in by	Cer												
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the besi	t of my kno	wledge, death	occurred at	t the time	e, date and	d place, a	nd due to the ca	ause(s) and	I manner as st	ated.
	the Print 24 the Francisco	Medical	one)	and manner s	tated.									
	or series	2	29b. Signature and title of certifier	+ 01	1	4.5	29c.	License	number	1-3	] 2	9d. Date sig	gned (Month,	Day, Year)
•	5		, mergan	xuf	m	-11		De	663	$\infty$	200	65	epti	
			30. Name and address of person who co	ompleted cause of	death (Iten	23a) (Type, I	Print)	11.	0		. 11	0	/ -	
			margant à Kai	ser mo	_ /,	5019	arrett	no	gerier	24	carten	d. l	1d 213	550
	Sta Registr		31. Date filed (Month, Day, Year) SEP = 1 20	32. Regist	rar's Signa	Lure	carle 3		,	•				
115	ricgisti	ea 1	S 120 1	1000	BETTE ST	TO THE STATE OF TH	11.11.11							

		1 - For State Registrar  1. Decedent's Name (First, Middle, Las		Cei	tificate o	of Death	2. Date of Deat		3. Time of Death		
Physici /Medio	an		FFBERGER			FFBERGE	R OS	23 06	1541 M		
Examin		4a. Facility Name (If not institution, give				n, or Location of Dea		4c. County of Dea	eth		
Funeral Director		SHOCK         TRAUMA           5. Social Security Number         6. Security Number           219-66-7177         1.1		(In yrs. last birthday) 55 Yrs.		ar If Under 24 Hrs	(Month, Day,		rthplace (State or Foreign ountry)		
pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	eation		March 1,	1951   Ma	aryland  10d. Inside City Limits		
Marylan I-f ehow	tor		ltimore	Pikesvi					1 ☐ Yes 2 ☐ No		
in the	Director	10e. Street and Number	01020	TINCOVI	10f. Zip Code	е	1	0g. Citizen of What C	ountry?		
23a c		9030 Balin Cou	ırt		212	08		USA			
and 21215-0036  be filed within 72 hours after death with the Maryland hall Hygiene.  do other than "natural", or Items 23a or 28a-f show event, the Mydical Examinar must be notified.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	'	Was Decedent of Yes, specify C	of Hispanic Origin? (suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: Wh			
15-0	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during most of wa	orking	16b. Kind of Business			
iryland 212; should be filed within to Mental Hygiene. marked other than matic event, the Mental Hygiene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		ver Worl			None			
be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumame)			
arylai should b ind Ment marke umatic e	To	Anthony Harris Ir						ene DiPaula			
<u>a</u> 2 2 <u>a</u> 3	o Y	19a. Informant's Name/Relationship (7) Diane Jones Ansar		1	_			, City or Town, State,			
C = 44 F	-	20a. Method of Disposition	1/ Sister	20b. Place of Dispo				e, MD 2083 20c. Location - City or			
Seltimor mit. Pages Dep. riment of important: if its any nlury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metropolita		orv Aug	ust 25,	Alexandria	, Virginia		
SBeltimore, cmit. Pages 1 at Dept. riment of Heal Important: if item any injury or othere.		21. Signature of Funeral Service Licen	see	r <sup>2</sup> i	Name and Add	dress of Facility Collins	Funeral	Home Inc.			
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ne death. Do not ent	er the mode of o	ersity Bly dying, such as cardia	rd, W., S.	ilver Spri	ng, MD 20901 Approximate Interval Between Onset and Death  MINOTES		
Examiner		Consentiable but our Wilson	SEPS1		SHOCK	ĸ			WEEKS		
68760, tificate be executed gphysician and as the burial-transit.	al Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	co equence of):					WEEKS		
68760,	edical		d								
Records, P.O. Box ( The law requires that the death certivate has been signed by the attending  bage 2 should be detached for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
cords, P w requires that been signed b	ed by Pł	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause	given in Part I.	23e. Did tob	pacco use contribute t es 2 ØNo 3 ☐ P	o the cause of death?		
Division of Vital Records, for attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be on	Complet						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of s		
Vita ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only on	θ)			
Physical direction	7	1  Nes 2 No <b>VECLINED</b> 27. Manner of Death	1 Inpatient		I 3 DOA			ence 6 Other (Spe	ecify)		
Vision of Vital Attending Physician: ir death. •ctor: Atter this certificaby the funeral director.	atlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	(ear) Injury	٧	njuryat Vork? □Yes 2 □No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division of Attence after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office	сө	28f. Location (St City or Town	reet and Number or R n, State)	fural Route Number,		
Hospita 24 hours Funersi tety filled	edical C	29a. Certifier (Check only one)  1 Certifying Ph. 2 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	xamination and/or in	n occurred at the vestigation, in m	e time, date and plac by opinion, death occ	e, and due to the caurred at the time, di	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
To the within 2 To the complet	Me	29b. Signature and title of certifier				ense number	2	9d. Date signed (Mon			
V		· /M	_ M.O.		D	17643		8/23/20	006		
•		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print)	0.	.0- 1-				
Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar	TRAWA (	ENTER	DAUTA	DOKE MO				
Registr		AUG 28	2006	US A	MARCE						

By23A(B) OK per D. Barbone

Please Type or Print in Black Indelible Ink Arit Archibong Inyang State of Maryland / Department of Health and Mental Hygiene 28932 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) . Date of Death Physician/ Medical Examiner Arit Archibong Inyang 2325 hrs August 24, 2006 Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Director 508-92-4712 Country) Nigeria 1 M 2 X F 6/1/1949 Usual Residence of Decedent 10b, County Oc. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show Maryland Prince George's death with the Maryland Cheverly Director 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? notified at 6329 Landover Road 20785-1329 U.S.A. items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, þe Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. African 1 Never Married 2 X Married 2 X No Widowed 1 Yes 2 X No specify. Divorced f Yes, Give Yea Specify: American "natural", Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 tment of Health and Mental Hygiene.
rtant: If item 27 is marked other than
or other traumatic event, the Medical Baltimore, MD 21215-0036 12 Certified Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be unavailable Jenny Udoh unavailable 19a Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)20011ဥ 931 Longfellow Street, NW #110, Washington, DC Princess Eno A. Inyang -20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Page
Department of
Important:
injury or oth Fort Lincoln Cemetery 9/16/2006 | Brentwood, Maryland Donation 5 Other Specify 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signal re of Funeral Service Lic. 4739 Baltimore Avenue, Hyattsville, MD 20781 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Death Torso injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed d and Physician/Medical g physician a UNPENDED AMENDED item #4a. perME.g859.9/13/06 TT Division of Vital Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No 1 V Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day Year) Aug 24, 2006 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto fixed object collision 2255 hrs Natural 1 Yes 2 🗸 No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Old Georgetown Road @ Kingswood Road, Beth (Specify) Local Street the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 25, 2006

111 Penn Street, Baltimore, MD 21201

**ORIGINAL** 

nd of ress of person w o completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner

SEP 0 I 2006

Registra

•		•	1 - For State Registrar	State of Maryland	-	artment of H			Reg. No. 2 (	006	28933
ı	Physici	an	Decedent's Name (First, Middle, L					2. Date of Dea Month	Day	Year	Time of Death
10/2	/Medic Examin		Mollie E. J 4a. Fecility Name (If not institution, g			4b. City, Town, or	Location of	August Death	28 4c. County		14:35 M
来				land Hospital			Clint			ince Ge	
	Funeral Director		5. Social Security Number 6. 579–44–0724	. Sex 7. Age (In yrs. la 1  M 2 🗓 F 97	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birt (Month, Da)	y, Year)	9. Birthplace Country) Mary1	(State or Foreign
	ס		Usual Residence of Decedent					001. 20	, 1900		
	Aarylar I ebow	5	10a. State 10b. County		, Town or Lo						Inside City Limits  1  Yes 2 □ No
	r 28s-f	Director	Maryland Prince 10e. Street and Number	George's		10f. Zip Code	inton_		10g. Citizen of	What Country?	)
	th with	ai D	9106 Pineview	Lane			207	35	Uni	ted Sta	ites
က္	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other than "netural", or items 23a or 28s-f ehow aumatic event, the Medical Examinar must be notified at	/ Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba	ispanic Origii n, Mexican, i Specity:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Rad Bla Specif	ce - American I ck, White, etc. Afric	
Ş	tural',	ed by	3 ₩idowed 4 □ Divorced  15. Decedent's	Year or Dates:		dent's Usual Occupa				Ameri	
212	hin 72	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most o	of working	100. 14110 01 0	30110334110400	.,
2	ygiene ygiene rt.	Соп	12th			Domes				rivate	
and	d be fill	Be c	17. Father's Name (First, Middle, La	· Diggs			18. Mother:	s Name (First, Middle, Ada	Hood	ne)	
Maryland 21215-0036	permit. Pages 1 and 2 should bu Department of Heelth and Menta Importent: if Item 27 ie marked any injury or other traumatic en	٦	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	and Number	or Rural Route Number		State, Zip Coo	de)
Σ,	and 2 eelth a m 27 i		Sheila Locke/Gr					, Clinton,		735	
Baltimore,	ages 1 nt of H : if ite		20a. Method of Disposition  1X Burial 2 Cremation 3	Linesitoval itotti State		nsition (Name of matory or other place		Date // /2006	20c. Location		
	nit. Pa artmer ortent injury	1	4 □ Donation 5 □ Other (Special Signature V Funeral Service Lice	A		Iemorial ( 2. Name and Addres				uitland Home	I, MD
ñ	Per gen gen gen gen gen gen gen gen gen gen		> John T	Stewart II		4001 H	Bennin	g Rd., NE			19
	Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused the teath, ly one cause on each line.	A		g, such as ca	ardiac or respiratory ar	rest,	Int	proximate erval Between aset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consequ		trum 1					
	Examiner	15	Sequentially list conditions,	b. Due to (bride a consequi	anna ili						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 40 4 001/2040	31103 017.						
,097	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	ence of):						
00	physics the bu	dical		d							
9 XC	death certific: ettending pl	n/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Da	ite of delivery	
P.O. Box	Attending Physician: The law requires that the death certifics in death. sctor: After this certificate has been signed by the ellending pt by the funeral director, page 2 should be delached for use as it.	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mo	onth Day	y Year
	ires that the de signed by the e I be detached f	<u>۾</u>	Part II. Other significant conditions	Alzher merli Type	lting in the u	nderlying cause give	en in Part I.		obacco use con		ause of death?
202	w requ	Completed	30000	170	/			24a. Was		Were autopsy	findings available
Be	The la	ошо							rmed?	prior to comple death?	etion of cause of
/ital	cian: ertifice ector, p	Be	25. Was case referred to medical examiner?	U				of Death (Check only o			
6	Physic rthis c ral dir	To	1 ☐ Yes 2 ☑ No  27. Manper of Death		ER/Outpatie		4 🔲 INUIS	sing Home 5 Resid		(-7	
<u>0</u>	nding ath. r: Afte e fune	ation	Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	Worl	k? Yes 2∐No	ĺ	. ,		
Division of Vital Records,	after designation of the after designation of the designation of the designation of the after a firm of th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			reet, factory, office		28f. Location (\$ City or Tox	Street and Numi vn, State)	ber or Rural Ro	oute Number,
	To the Hospital or Attending Physician: The law requir within 24 hours after death.  # the Funeral Director: After this certificate has been sign the Funeral Director: After this corrilicate has been significant filled in by the funeral director, page 2 should	Medical C	29a. Certifier Certifying (Check only 2 Medical Exone)	Physician: To the best of my knov eminer: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the tim vestigation, in my of	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as stated and due to the	d. e cause(s)
	within to the comple	Me	29b. Signature and title of Pertifier			29c. License	e number		29d. Date signe	ed (Month, Dey	r, Year)
)	(1)		► Nah	MD		D000	55120		August	29 20	206
	Uge		30. Name and address of person wh	0 1	23a) (Type,		310 1	10-1-1	DC 20	n/la	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	-c suite	210 0	Nonhinghon	DC 20	いっと	
	Regist		SEP 0 1 2006	Blown M Again	We .						1

06-06660 Maureen Johnson Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	te Certificate of Death Reg. No. 2006									6 28	143			
Physici	_	1. Decedent's Name (First, Midd	st, Middle,Last) 2. Date of Death											3. Time of Death	n	
edical Exami		Maureen I.	Johnson								Month Septembe	Day er 5, 20	006 Year		1655 hrs	
		4a. Facility Name (if not institution		d number)		41	b. City, Tow	n, or Lo	ocation of				County o	of Death		
		6402 Oakton Way					Hyattsv	ille				P	rince G	eorge	's	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	nday)	If Under 1	Year	If Under	24Hrs.	8. Date of Bit	rth(MM/E	DD/YYYY	9. Birt	hplace (State or	
Director		216-46-5829					Months	Days	Hours	Min				Foreig	n	1
5501.01			1 M 2X	F	52	Yrs.					01/29/	1934	+	Col	intryMary1a	ına
8		Usual Residence of Decedent  10a, State 10b, County		100	City, Town	or Locatio									10d. Inside City	Limite
w. an			-												1 X Yes 2	
and Fsho	ō		e George	e's	Chev	erly										INU
ne Maryland or 28a-f show any fied at once.	Director	10e Street and Number					10f. Zip Co	ode			1	0g. Citiz	en of Wh	at Coun	itry?	
ith the Maryland 23a or 28a-f sho notified at once.	듑	6402 Oakton W	ay				20	785				U	SA			
with the is 23a see noti	Funeral	11. Marital Status	12. Was	Decedent Eve	r in U.S.						ify Yes or No		14. Race		can Indian, 8lack	ζ,
eath item	ar l	1 Never Married 2 M	allicu	ed Forces?	No	If Ye	s, specify C	Cuban, I	Mexican,	Puerto Ri	can, etc.)		White	, etc.		
her de		3 Widowed 4 Div	orced If Yes, Give	Year 2 A	NO	1	Yes 2X	No	specify:				Specify:	Wha	Lte	
2 hours after "natural",  Examiner	d b	15. Decedent's Education (Spe	or Dates: ecify only highest	grade complet			s Usual Oc					16b. K	ind of 8us	siness/li	ndustry	
2 hor "na	ompleted	Elementary/Secondary (0-12)	Colle	ge (1-4 or 5+)		turing mo	st of workin	ıg life. D	OO NOT u	se retired	<b>d</b> )	Pr	ince	Ged	orge's	
5-0036 led within 7/ tygiene. other than the Medical	힐		4	<b>+</b>	R	egis	tered	Nu	rse			Н	ospi	tal	-	
d with	ő	17. Father's Name (First, Middle	, Last)					18	3. Mother's	Name (F	irst, Middle,	Maiden (	Surname)			
115 al Hy redo	Se C	Ralph Lawrenc	e Johnso	on					I	Alice	e Murp	hy				
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	o B	19a. Informant's Name/Relations	ship (Type, Print	)	19b	Mailing	Address (	Street a	and Numb	er or Rur	ral Route Nur	nber, Cit	ty or Towr	n. State.	Zip Code)	
MD and 2 showalth and 1 is 27 is raumatic	-	Alice M. Johns		•	5	306 -	<del>56∏</del>	AV	ay,	ast	River	lale	2010	<b>. 2</b> 0	737	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment offer left hand. Bygiene, in the ment offer left hand bygiene, and "maturral", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		· · · · · · · · · · · · · · · · · · ·	20b. Place o						Date				Town, State	
Ore ges 1 of H If ii		1 X Burial 2 Cremation	n 3 Remov	al from State		ory or other				0 /11	1,0000				16 1	,
Pag ment ment tant:		4 Donation 5 Other S			Ft. Li						L/2006	Br	entw	ood,	Maryla	nd
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hydew Important: If item 27 is marked other in migury or other traumatic event, the Med		21. Sig the e of Funeral ervice	Licensee	- 1		22. Na	ame and Ad	ldress o	of Facility	Gaso	ch's F	uner	al H	ome,	P.A.	
E. E Q & W		1 Alemil Porns	Alumi troffer 10(373 4739 Baltimore Ave., Hyattsville													
Physician		3a. Part I. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate In Between Onse				
/Medical xaminer	Ŋ, N	Immediate Cause (Final disease											Death			
Adminici		or condition resulting in death)	Due to (or	as a conseque	ence of):											
	L	Sequentially list conditions,														
	Examiner	cause. Enter Underlying Cause														
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseque	nce of):											
xecuted n and - transit		events resulting in death) cast	d.													
ਾ ਲੋਵ	n/Medical	X UNPENDED	AMEND	ED ,	loo DIT	07.0	2 6	1.07	050	0/15/	'04 PPP					
8760, ifficate be ex ng physician as the burial	led	IF FEMALE:	1 22c If	item# /es, outcome o	23a,PII	,2/,2	Sa-t,pe	erME,	g859.	9/15/	06 TT	224	. Date of	dolivory	<u> </u>	
S ig	5	23b. Was decedent pregnant in t	la a		2 pregnancy	Feta	al death	3	Ectopic	pregnanc	cy		Month		ay Yea	ar
30x 6 death cerr ne attendii d for use a	cia	past 12 months?	4 F	regnant at time	of death 5		er (Specify									
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 V Un	iknown 9 🔲 L	Inknown												
O. I tt the lby t		Part II. Other significant condi	tions contribut	ng to death but	t not resulting	in the ur	nderlying ca	use giv	en in Par	t I.	23e. Did t	obacco u	use contri	bute to	the cause of deat	th?
P.O es that	þ	Hypertensive	cardiovas	cular dis	sease						1 Ye	s 2	No 3	Prob	ably 4 🗸 Unkr	nown
of Vital Records, P.O. Box 68 ing Physician: The law requires that the death cert After this certificate has been signed by the attendir tuneral director, page 2 should be detached for use a	Completed										24a. Was	an	24b. V	Vere au	topsy findings av	ailable
aw r aw r as b	횰										auto	osy irmed?		rior to c leath?	ompletion of caus	se of
Rec The 1	5										1 Yes			<b>✓</b> Ye	s 2 🔲 I	No
an:	Be	25. Was case referred to medica					26.		of Death (	Check on	ly one)					
Vit. ysici his o direc	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/0	utpatient	3 DOA	10	ther4	Nursing I	Home 5	Resider	nce 6	Other	Scene	
n of Vital Records, ding Physician: The law requir After this certificate has been s funeral director, page 2 should	1:1	27. Manner of Death	28a.	Date of Injury Month, Day, Year)	28b. 1	Time of In	jury 28d	. Injury	at Work?	2	8d. Describe	how inju	ry occurre	ed		
	tiol		nding Fa	1000000000000000000000000000000000000	06 Fn	d 4:3	) Pm 1	( Ye	s 2 x	No	unk					
isi Attı er de rectu	<u> </u>		200	Place of Injury				ffice bui	ilding, etc	. 2	8f. Location (	Street ar	nd Numbe	er or Ru	ral Route Numbe	r, City
Division tal or Attendi rs after death al Director: led in by the fu	Certification:	3 Suicide 6 X Cou		ecify) for	ınd in r	ocide	nce			110	or Town, S Hyattsv	State)	6402 (	Oakto	on Way	
Division of Vital  Hospital or Attending Physician: 24 hours after deats as after deats iely filled in by the funeral director.	2	29a. Certifier		100				no deta	o and play							-
Division  To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	Medical	(Check only certifying Fone) 2 Medical Ex	Physician: To the aminer: On the b													
To t To t	Jed	29b. Signature and title of certifi	and man	ner stated					number							
	_	200. Signature and title of certifi	Ilm n.	$\sim$											nth, Day, Year)	
		alded	Hell	Lar			'	D.C.M	I. E.			Sep	tember	6, 20	Ub	
(0 (1)		30. Name and address of perso										•				
Chr @		Carol Allan, MD As	ssistant Medi	cal Examin	er 111	Penn S	treet, Ba	altimo	re, MD	21201						
S	tate	31. Date filed (Month, Day, Year	)	2. Registrar's S	Signature	9 4										
		SEP 0 8 2	nae 🎉	2-4	M. A	ages.										

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Jr. Steven Johnson, 8:11 A. M August 27, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 34 212-11-1341 Yrs September 11, Washington, D.C. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. State 10b. County 1 Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "netural", or iteme 23a or the Medical Examiner must be r 20906 2404 Sun Valley Circle United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s filed within 72 hours after di i Hygiene. other than "netural", or item Yes 2X No f Yes, Give fear or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: B1ack Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Interstate Brands Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Retail Sales Clerk Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill I Health and Mental H tem 27 Is marked oth Be Johnson, Sr. Doris Winters Steven Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
eny injury or other trau 2404 Sun Valley Circle; Silver Spring, Maryland 20906 Doris M. Clayton (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 30, 2006 Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 si perforn 1 ☐ Yes 1 Yes 2XXNo 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 📉 No 1 Inpatient 2X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D45471 August 28, 2006 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

State Registrar

SFP 0 1 2006

2086

DHMH 17 Rev 1/2001

32. Registrar's Signature

Yeheyis Negussie, M.D.; 1111 Spring Street; Suite 214; Silver Spring, Maryland 20910

ician	1 - Stata Ragistrar  1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Year	3. Time of Death
dical	CHARLES P. JONES,			4h City	Town, or Location of Deat		23, 2006 4c. County of Death	9:30P M
niner	1302 SPLIT ROCK I				ORT WASHING		PRINCE (	
al	5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	If Under Months		8. Date of Birtl	n a Rieth	nplace (State or Foreiguntry)
or	369 60 3/34	XM 2□ F (	51 Yrs.	WOTHING	Days Hours Will	SEP. 18	, 1944 ILL	INOIS
	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limit
ţ	MD PRINCE GE	ORGES FOR	RT WASH	INGTO	N			XXYes 2□N
Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of What Cou	untry?
rail	1302 SPLIT ROCK I		10 101		20744		UNITED S	
Funeral	11. Marital Status 1 □ Never Married XXMarried	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes ※XXNo	J.S. 13. V	Yes, spec	lent of Hispanic Origin? (S ofy Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Amer Black, White	
þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	□ Yes }	No Specify:		Specify: BL	ACK
Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	ent's Usua kind of wo	al Occupation rk done during most of wo se retired)	rking	16b. Kind of Business/I	ndustry
m	Elementary/Secondary (0-12)	College (1-4or 5+)					MOLI DDOMIN	ene buttor
	17. Father's Name (First, Middle, Last)	3 YRS.	DAI	A ADM	INISTRATOR  18. Mother's Na.	me (First, Middle,	TOLL BROTHI	FK2 DOILDE
To Be	CHARLES P. JONES,	II			PEARL			
<b> </b>	19a. Informant's Name/Relationship (7		19b. Mailin	g Address	(Street and Number or R		r, City or Town, State, Z	ip Code)
	GERI JONES / WIFE	Ε	1302	SPLIT	ROCK LANE	FORT WA	ASHINGTON, N	1D 20744
	20a. Method of Disposition  XIX Burial 2 Cremation 3	20b.	Place of Dispos cemetery, cren	sition (Nan natory or o	ne of ther place)	Date	20c. Location - City or 1	Town, State
	'4 □Donation 5 □ Other (Specify	FOI			EMETERY 08/3		BRENTWOOD,	
once.	21. Signature of Funeral Service leicen		22		HALL'S SFAFUNEI			
<u></u>	23a Part 1 Enter the disease or commo	directions that caused the dea	th. Do not ente		SUITLAND RO		TLAND, MD Z	20746 Approximate
3	23a. Part1 Enter the disease, or comp shoc for heart failure. List only of Immediate Cause (Final	one cause on each line.	uni Bonoroni	or the mea	o or dying, saon as sardia	o or roopmatory arr	1000,	Interval Between Onset and Death
in al	disease or condition resulting in death)	a. LUNG CANCER  Due to (or as a conse						
r			quonos ory.					
je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of):					
Examiner	Cause (Disease or kijury that initiated events resulting in death) Last	c						
	resulting in death) Last	Due to (or as a conse	quence of):					
edicai		d						
/Me	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of deliv	verv
Physician/M	in the past 12 months?	1☐Live birth 2☐Fet 4☐Pregnant at time of		Ectopic pr Other (sp			Month	Day Year
hys	9 □ Unknown	9□ Unknown						
by P	Part II. Other significant conditions of		sulting in the ur	nderlying c	ause given in Part I.		bacco use contribute to	
ted	HEAD AND NECK CAN	ICER				YXX	es 2 No 3 Pro	bably 4 Unknow
ompieted						24a. Was a autop	sy prior to c	opsy findings availab ompletion of cause of
Con						perfor	med? death? 2⊠No 1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only or	-1-	
tion: To Be C	1 ☐ Yes 2☐XNo  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of		8c. Injury at		ence 6 Other (Spec ow injury occurred	ify)
tion	1XXNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 □ Yes 2 □ No		. ,	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		et, factory	, office	28f. Location (S City or Tow	treet and Number or Ru	ral Route Number,
Cert	TIOMIO!	building, etc. (Spec				Ony or You	n, Siaie/	
	29a. Certifier XX Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kn iner: On the basis of examin	owledge, death	occurred restigation,	at the time, date and place in my opinion, death occi	e, and due to the ourred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
Medical	one)  29b. Signature and title of certifier	and manner stated.		290	License number		29d. Date signed (Month	Day Year)
1	006	110		250	D60050		AUGUST 29	
, .	1 100100				טכטטטע		AUGUSI 29	, 2000
	30. Name and address of person who	completed cause of death (Its	m 23a) (Tuno	Print)				

			For AVEND#3  State Registrar AAC	24A per F 10 HEALTH	hy. State o	f Marylan 8/25/06	d / Dep <i>Ce</i>	artment of I	Health a Death	and Me	ental Hyg	iene .g. No. 20	06	28937
F	Physici /Medic		1. Decedent's Name	(First, Middle,	Last)					1	2. Date of Dear Month	Day /	Year Poolo	3. Time of Death 7:00 PM
	Examin		4a. Facility Name (If	not institution, g				4b. City, Town,	or Location o	of Death	1	4c. County		1 - 1
			Anne Arus		dical Cen	T. Age (In yrs.	lact highday	Anna, If Under 1 Year	OCL iS	24 Hrs   6	B. Date of Birth		e An	olace (State or Foreign
	Funeral Director		5. Social Security Nu 290-72- 6		12M 2□F	7. Age (III y/s.		Months Days		Min.	Month, Day,	(Year) 1927	Coul	office (State of Foreign
	pu ,		Usual Residence of			100 Ci	y, Town or L	antin -					1.	0d. fnside City Limits
	Maryla a-f ehov	tor	MD	Anne A	rundel	100. CII	y, rown or c	Arnold						1 ☐ Yes 2X No
	or 284	Director	10e. Street and Num					10f. Zip Code	1010		1	0g. Citizen of V		ntry?
	s 23a	rai	509 Bay	Green L		edent Ever in U	C 12		1012	ain? (Cana	ifu Voc or No		SA	can Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents if Itam 27 is marked other than "natural", or Items 23a or 28a-f show appripring yor other treumatic event. Ye Musical Examinar most be notified at annote.	by Funeral	11. Marital Status  1 ☐ Never Marrie  3 ☒ Widowed		Armed Fo	rces? 2 ∐ No	.3.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☆ No		i, Puerto A	ican, etc.)	Blac	k, White, Whi	etc.
2-0	72 ho natur	eted	(Speci	15. Decedent's fy only highest			(Give	dent's Usual Occu kind of work done	durina most	t of working	g	16b. Kind of Bu	siness/In	dustry
121	within iene. then	Completed	Elementary/Secon		College (1	-4or 5+)		DO NOT use retire rehouse M	•	2		Di	stil	lery
Maryland 21215-0036	d be filed antal Hyg red other c event,	Be	17. Father's Name (A		ist)		1			r's Name (		Maiden Sumam	ө)	
ary	shouls and Me mark sumati	ပ	19a. Informant's Na	me/Relationship				ng Address (Street						Code)
e, M	1 and 2 4ealth am 27 i		Mark Kie		on	20b. F	_	Bay Gre	en Dri	Lve, A	-	MD 21 20c. Location -	012	own State
Baltimore,	Pages ment of I ent: If Ita			Cremation 3	Removal from	State	emetery, cre	matory or other pla st Memori		Aug.		Annapo	•	
Balt	permit. Depart Import any inj		21. Signature of Fur	Peral Service Kil	pensee Du	Sam	2	arrancom 195 Gov.	% Sone Ritchi	e Hw	A. Seve y, Seve	rna Par rna Par	k Fu k, M	neral Home D 21146
	Physi <b>cian</b>		23a. Part1. Enter the shock, or hear lamediate Cause (to isease or condition	Final	ompfications that can be cause on e	aused the deal		ter the mode of dy		cardiac or	respiratory arr	est,	-	Approximate Interval Between Onset and Death
	/Medical Examiner		esulting in wath)		Due to	or as a consec	uence of):		`					
	uted 1 Insit	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	riying Injury	Due to	or as a consec	uence of):							
8760,	cate be executed physician and the burial-transit		that initiated events resulting in death) L	ast	Due to	or as a consec	uence of):							
Ö	tificate ig phys as the	edic			a									
.O. Box	death cer e attendin ed for use	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 and 12 yes 2 9 Unknown	months?		irth 2 ☐ Feta ant at time of c	Ideath 3	⊒Ectopic pregnand ☐ Other (specify) _	ру			23d. Dat Mor	e of defiventh	ery Day Year
α.	requires that the de een signed by the hould be detached	Ď	Part II. Dther signifi	cant condition	s contributing to de	eath but not res	ulting in the	underlying cause gi	ven in Part I.				ibute to t	he cause of death?
COL	> 20 70	letec						-			24a. Was a		Vere auto	ppsy findings available
of Vital Records,	The law isete hes by	Completed									autore periori	ned? c 2█No 1	rior to co leath? Yes	ppsy findings available impletion of cause of
/ita	ysician: Th is certificete director, peg	Be	25. Was case referr	red to medical	11 24.4	,				of Death	(Check only on			
of \	Phys this ral dii	<u>۲</u>	1 Yes 2 Death		Hospital: 1		ER/Outpatie	III SLI DOA				ence 6 GOth		(y)
ion	Attending I r death. ector: After by the funer	ation	1 ☐Natural 2 ☐ Accident	5 ☐ Pending investiga		of Injury th, Day Year)	fniury	Wo	ork? ]Yes 2∐t		30. D0301100 110	ow injury occurr		
Division	al or Attences after death	Sertification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad 286. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, s fy)	reet, factory, office		28	Bf. Location (Si City or Town		er or Rura	al Route Number,
	To the Hospital or All within 24 hours after of To the Funeral Directomplately filled in by	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	th occurred at the threating the threating the threating at the threating threating the threating threatin	ime, date and opinion, deal	d place, ar th occurred	nd due to the c d at the time, d	ause(s) and ma ate and place, a	nner as s and due to	tated. o the cause(s)
	To the To the Complet	Me	29b. Signature and	title of certifier	7 (1	$\wedge$		29c. Licen	se number		2	9d. Date signed	(Month,	Day, Year)
			30	Weyl (	XWX U	death,(Ite	n 230) (Tun-	Paritie)	1656	14		OV	210	0
	7+	_	30.   arhe and addre	KKF	FAIRM	10 40	NA	NOPTE	4)3(	JD F	MM	HOSH	CM	40
	Sta Regist		31. Date filed (Mont	h, Day, Year) AUG 2 5		egistrar's Sign	ature	book		*				,

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

tis

100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

			- For State of Maryla   State of Maryla   State of Per verb.	nd / Department of Health and Ment G859 09/12/06dbb Certificate of Death	al Hygiene 2006 28939
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Da	te of Death onth Day Year  3. Time of Death
Spinis	/Medic Examin	al	DONALD POTTER  4a. Facility Name (If not institution, give street and number)	KEEL Seg	otember 3,2006 3:15 A <sup>M</sup> 4c. County of Death
	Examin	C1	Frederick Memorial Hospi		Frederick
	Funeral Director		058-32-1383 1 <sup>™</sup> M 2□F	5. last birthday) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. (MAUS	te of Birth Onth, Day, Year) 20, 1940  9. Birthplace (State or Foreign Country) Pennsylvania
	/land			city, Town or Location	10d. Inside City Limits
	Be-f et	Director	Maryland Frederick	Frederick	1 ☐ Yes 2 🛣 No
	ath with the 23s or 21	rai Dire	10e. Street and Number 6739=D South Clifton Road	10f. Zip Code 21703	10g. Citizen of What Country? U.S.A.
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Pyglene. Depertment of Health and Mental Pyglene Important: if Item 27 is marked other then "naturel", or Iteme 23a or 28e-f ehow empty injury or other traumatic event, the Medical Examination in initial at another. Applea.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates: Vie	U.S. 13. Was Decedent of Hispanic Origin? (Specify Y II Yes, specify Cuban, Mexican, Puerto Rican, that I □ Yes 2 ☑ No Specify:	es or No- etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: White
5-0	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry
212	d withii giene. or then	Be Completed	Elementary/Secondary (0-12)  College (1-4or 5+) 5+	V.P. Operations	Coal Company
	be tile ital Hys id othe event,	Be	17. Father's Name (First, Middle, Last) Donald Potter Keel Sr	18. Mother's Name (First Betty	, Middle, Maiden Sumame) Wilson
Maryland	should nd Mer marke	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Rout	
	and 2 Balth a m 27 is		Theda McPheron-Keel, Wife	6739-D South Clifton Roa	
Baltimore,	Pages 1 ment of He ant: if Iter lury or oth		1 ☐ Burial 2XX remation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify)	Place of Disposition (Name of cemetery, crematory or other place)  ithsburg Crematory Spe 8, 20	
Ball	permit Depert Import eny in		21. Signature of Europa Service Licensee  MO07	Xeeney & Basford P. 106 East Church Street	A. Funeral Home , Frederick, MD 21701
			23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	1	ratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conse	equence of:	unhour
	Examiner		n. 1.	Les	unknown
	rted	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):	
0	icate be executed physicien and s the burial-transit	edical Examiner	that inflated events c	equence of):	
68760,	physic physic s the bu	dica	d		
P.O. Box (	The law requires that the death certif sie hes been signed by the ettending page 2 should be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year
	uires that signed b		Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
Division of Vital Records,	The law rec ste hes bee page 2 shou	Completed		2:	4a. Was an autopsy autopsy findings available prior to completion of cause of death?  Yes 2 ☑ No  1 ☐ Yes 2 ☑ No
Vita	ician: certific rector,	Be	25 Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Che	
ō	g Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28d. D	PAesidence 6 □Other (Specify) escribe how injury occurred
sion	eath. or: Aft	catio	2 Accident investigation	M 1 Yes 2 No	
<u>S</u>	tal or Att rs after d el Direct	Certification:	4 Homicide determined building, etc. (Spec	city)	cation (Street and Number or Rural Route Number, ty or Town, State)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death occurred at the time, date and place, and du nation and/or investigation, in my opinion, death occurred at t	e to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
	To t with To t	Z	29b. Signature and title of certifier	29c. License number 04/378	29d. Date signed (Month, Day, Year)
	25		30. Name and address of person who completed cause of death (It	e Frederick MA 71	702
	Sta Registr		31. Date liled (Month, Day, Year) SEP 1 2 2006 32. Registrar's Sig.	nature	

			1 - For State Registrar	State of M	laryland /		irtment of H		d Mental	, ,	ne No. 20 (	าร	28940
			Decedent's Name (First, Middle,	Last)					2. Date of	f Death			3. Time of Death
ı	Physici /Medi		Kathleen B. Lei	zure					Avai	it 2		ar AG	05:55 A
	Examir		4a. Facility Name (If not institution,	give street and number	11 0	,	4b. City, Town, or	Location of D			4c. County of I		
			Peninsula Keg	ional Med	ICAT CEN	Her	Day	Sour	1		Wicon	rico	
L	Funeral Director		003-09-7682	5. Sex 7. A 1 M 2 ★F	ge (In yrs. last I	Yrs.	If Under 1 Year Months Days	Hours I	Min. (Month	f Birth 7, Day, Ye 1/192	ar) 9.	Birthpl Coun	ace (State or Foreign ry) NH
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					10	d. Inside City Limits
	Maryll febo	ō											1 ☐ Yes 2 🛣 No
	death with the Maryland rms 23s or 28s-f ehow	Director	MD Worc	ester	Ber1	Lin	10f. Zip Code			10g.	Citizen of Wha	it Count	rv?
	3a ol	i i	9 Camelot Circl	e			2181	1			USA		
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces		13. V	Vas Decedent of Hi Yes, specify Cuba		? (Specify Yes o	r No-	14. Race -		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other than "naturel", or itams 23a or 28a-f show armetic event, the Madical Examinar must be notified at	by	1 ☐ Never Married 21☑ Marrie 3 ☐ Widowed 4 ☐ Divorced		No		Yes 21 No	Specify:	derio mozn, etc.	•1	Specify:	wnite, e	White
Ģ	72 ho	Completed	15. Decedent's (Specify only highest	Education	16	Sa. Deced	ent's Usual Occupa	ation	wading	16b	. Kind of Busin	ess/Ind	ustry
7	ithin Ban	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. E	kind of work done of OO NOT use retired	) )	WOIKING				
2	led w lygier her th		12	L		H	omemaker				Own H	lome	
מש	be fi	Be	17. Father's Name (First, Middle, L.	•					Name (First, Mi				
<u> </u>	d 2 should be the and Mental is marked o traumatic eve	ဥ	George Bergero			Ob. 14-31-			riet Ch				
Z				р (тура, етт)	13		g Address (Street a					te, ∠ıp	Code)
	1 and Health tem 27 other tr		Francis Leizure 20a. Method of Disposition		20b. Place	of Disnos	amelot Ci sition (Name of	1	Berlin,	_	Location - City	v or Tov	vn. State
<u> </u>	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		,		natory or other plac	·	100 10006				
		. 1	21. Signature of Funeral and ice Li		Раре		open Cres		28/2006		Frankfo		
Ra	permit, Depertr Imports eny inju		Will fo	must			108 Willi				Funer 21811	aı .	nome
			23a. Part 1. Enter the disease, or c shock, or heart failure. List of	mplications that cause	d the death. Do						21011		Approximate
	Physician	4	Immediate Cause (Final	my one cause on each	1110. 12 m ( 2 s.	4,40			ilure				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	s a consequenc	e of):	VETOU	Fra	11000				
	Examiner		Convention lies and distance	b									
<i>p</i>	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequenc	e oi):							
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ď,	tate be executed physician and the burial-transit	<u>E</u>	roodining in dodairy cast	Due to (or as	s a consequenc	:e or):							
978		dicai		d		_					· · ·	-	
×	death certific e attending p ed for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy	33441	100				024 Date -		
ŏ n	leath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of Month		y Day Year
oj .	at the de by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	_		(-,,/,						
ري ح	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to death I	but not resulting	j in the un	derlying cause give	en in Part I.	23e. I	Did tobacc	o use contribu	te to the	cause of death?
ğ	w require been sig should b	ed t							_ 1	☐Yes	2 □ No 3 □	] Proba	bly 4 Unknown
Hecords,	awre Is bee	Completed								Mas an	24b. Wer	e autop	sy findings available
r	o - 6	E								iutopsy erformed es 2 🔀	? deat	no com h? Yes 2	pletion of cause of
VITAL	ician: Tr certificete ector, pag	Bec	25. Was case referred to medical examiner?					26. Place of	Death Check of				
> 5	Physician: r this certific ral director,	2	1 Yes 2 No	Hospital: 1 🗘 Inpati		Dutpatient	3□ DOA Othe	er: 4 🗌 Nursin	ng Home 5 🗆 F	Residence	6 ☐Other (	Specify,	
	ding P h. After t funera	e ::	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b ay Year)	. Time of Injury	28c. Injury Work	(7	28d. Descr	ibe how in	jury occurred		
DIVISION	tor:	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t he				Yes 2 □ No					
5	5 # 5 E	Certification:	4 Homicide determin	ed   286. Place of in	itc. (Specify)	farm, stre	et, factory, office		City of	on (Street Town, St	and Number o ate)	r Rural	Route Number,
-	spita ours neral filled		29a. Certifier 1 A Certifying	Physician: To the best	of my knowled	de death	occurred at the ten	a date and n	lace and due to	the cours	(e) and man-	r ge et-	tad
	호수들을	edical	(Check only Z   Medical E.	caminer: On the basis of and manner si	of examination a	and/or inv	estigation, in my op	oinion, death o	occurred at the ti	me, date a	and place, and	due to	the cause(s)
- 1	To the P within 2. To the F or mplets	Me	29b. Signature and title of certifier				29c. License	number		29d. I	Date signed (M	ipnth, D	lay, Year)
	-, 3		1/	-			155	1058			081	2	6/2006
			30. Name and address of person w	ho completed cause of	death (Item 23a	ı) (Type, F	Print)				/	V	-10 6
2	H7	05 a 10	Frank Aer	a In E.	Carro	11:	255 Print) 54- So	lishur	y me	2 ~	1801		
x (5)	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		1						
	Registr	ar	AUG 2	2006	لكر مناطقة	A	ment						

06-06460 Daniel Littleton

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate (	ot .	Death			Reg.	No.	UUb	2894	
Physici												
Medical Exami	iner	Daniel Gregory Littleto	n				Augus	t 28, 2	006	1	811 hrs	
Marine Marie		4a. Facility Name (if not institution, give street and number		41	c. City, Town, or Lo	ocation of De			4c. County of	Death		
		162 West Patrick Street			Frederick				Frederick			
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	_	If Under 1 Year	If Under 24	Hrs. 8. Date	of Birth(	MM/DD/YYYY)	9. Birthplac	e (State or	
Director		402-21-9805	29	,	Months Days	Hours	Min.	<b>-</b> 0	1077	Foreign	-	
			Y	rs.			Apri	.I Z,	, 1977	Country)	Japan	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	atio	n					100	Inside City Limits	
<b>*</b> .			Walker								Yes 2 XNo	
land f sho	5		Walker	5 V	TITE						Yes 2 2 No	
Maryland 28a-f show d at once.	Director	10e, Street and Number		- 1	10f. Zip Code <b>21793</b>			10g.	Citizen of Wha	at Country?	- '	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	ä	8369 Inspiration Avenue		- 1	21/93				USA			
with th ns 23a	Funeral	11. Marital Status 12. Was Decedent			Decedent of Hispa				14. Race -	American Ir	ndian, Black,	
leath w	ищ	1 Never Married 2 Married Armed Forces' 1 Yes 2	No If	f Ye	s, specify Cuban, N	Mexican, Pu	erto Rican, etc.	)	White,	etc.		
fter d		3 Widowed 4 X Divorced If Yes, Give Year	1		Yes 2 X No	specify.			Specify:	White	2	
urs a tura	d b	15. Decedent's Education (Specify only highest grade cor	npleted) 16a. Deced	lent's	s Usual Occupation	n (Give kind	of work done	16	b. Kind of Bus	iness/Indust	гу	
Cl 3 —	ompleted	Elementary/Secondary (0-12) College (1-4 or	5+) during	mos	st of working life. D	O NOT use	retired)				,	
36 thin 72 than than edical	ğ	12	Nev	er	Worked				None			
15-003( filed within Hygiene. d other tha	ГO	17. Father's Name (First, Middle, Last)				Mother's Na	ame (First, Mid	dle Maio				
1	Be C	Walter Littleton	Joan		,	Szyman	iack					
21215-0036 ould be filed within 7 I Mental Hygiene. s marked other than ic event, the Medica	To B	19a. Informant's Name/Relationship (Type, Print )			. Ntala	r, City or Town		2- 4-3				
Shou shou and N		, , , , , ,				sville,						
imore, MD 2 Pages I and 2 shou ment of Health and I lant: If item 27 is n or other traumatic		Walter Littleton/Father 20a Method of Disposition	tery.	Date								
S a la S la S la S la S la S la S la S		1 Burial 2 X Cremation 3 Removal from St	rtery,	Date	20	Oc. Location - (	Jity or Town	, State				
Page ent c		4 Donation 5 Other Specify:	Frederic	k	Cremator	y 8,	/31/200	6	Freder	ick, N	D 21702	
Baltimore, permit Pages I ar Department of He, Important: If ite		21 Signature of Funeral Service Licensee	22	. Na	me and Address of	f Facility	۵. دد	- 17		T	24	
		KOTO, MOCO	1	62	l Opossu	mt own	Pike i	rede	ineral erick,	MB <sup>m</sup> 217	<b>∕ið</b> 2 ∣	
Physician		23a/ Por I. Enter the disease, or complications that caused failure. List only one cause on each line.									proximate Interval	
/Medical			and the second s							Be	tween Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a cons		е	untoxicatio	on				-	Deari	
1		, h	squerioc or).									
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	equence of);							_		
	듵	cause. Enter Underlying Cause (Disease or injury that initiated										
	Examiner	events resulting in death) Last  Due to (or as a cons	equence of):									
executed an and al - trans		d										
	an/Medical	X UNPENDED AMENDED	em#23a.27.28a	. £	norME age	0/15/	O6 TIT					
68760, certificate be nding physicise as the buri	Me	IF FEMALE: 23c. If yes, outcome and the second seco		<u></u> I	penur, gab	9,9/15/	00 11		23d. Date of d	elivery		
as as	E S	23b. Was decedent pregnant in the past 12 months?	2 7	Feta	Ideath 3	Ectopic pre	gnancy		Month	Day	Year	
th ce	ici	4 Pregnant at	time of death 5	Othe	er (Specify)							
, P.O. Box 6 ires that the death ce signed by the attend be detached for use	Physicia	1 Yes 2 No 9 Unknown 9 Unknown										
P.O. s that the gned by e detach		Part II. Other significant conditions contributing to deat	h but not resulting in the	e un	derlying cause give	en in Part I.	23e. [	old tobac	co use contrib	ute to the ca	use of death?	
res th	d by						1	Yes 2	2 No 3	Probably	4 V Unknown	
ords, w requir s been s should t	Completed							Vas an	24b. W	ere autopsy	findings available	
law r has t	ğ		· · · · · · · · · · · · · · · · · · ·					utopsy erforme		or to comple ath?	tion of cause of	
Vital Records ysician: The law requi his certificate has been director, page 2 should	등									<b>✓</b> Yes	2 No	
ian:	Be	25. Was case referred to medical examiner?					ck only one)					
Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be		Hospital: 1 Inpatie	ent 2 ER/Outpatie	ent	3 DOA Ot	her Nu	rsing Home 5	Res	sidence 6	Other: Scen	ne	
of Vit ling Physic After this		27. Manner of Death 28a. Date of Inju (Month, Day, )	ry 28b. Time o	of Inj	ury 28c. Injury a	at Work?	28d. Desc	ribe how	injury occurred	1		
OD ath. he fu	흲	Natural 5 Pending Fnd 8/28		10	nm 1 Yes	s 2 y No	unk					
iSic Atte	ig	2 Accident investigation 28e Place of Ir	jury - At home, farm, str		*	dina, etc.	_	on (Stree	et and Number	or Rural Ro	ute Number, City	
Division pital or Attent ours after death heral Director: filled in by the	Certification	Suicide A Could not be determined	ound under tr		,	<b>3</b> ,	_ or Tov	vn, State	), 162 Wes	st Patr	ick Street	
ospit hour ners		4 Homicide		-		-	Frede					
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for a	Medical	(Check only Certifying Physician: To the best of m									20(6)	
To tl withi comp	edi	and manner stated.	and and investig	guill			at the title, i			_		
62533	Σ	29b Signature and title of certifier			29c. License n			29	d Date signed	(Month, De	ay, Year)	
12		Pot anon Pa	l 0, 2		O.C.M.	E.		A	ugust 29, 2	2006		
		30. Name and address of person who completed cause of c	leath (Item 23a)									
	st il		ledical Examiner	,	111 Penn Stre	et, Baltim	nore, MD 2	1201				
	tate			/			-					
Regis		SEP U H 2000	r's Signature	20	ME!							

			For Stete		State	of Mar	yland / Depa	artment of H		d Mental Hy	giene	2006	28942
			Registrer	/Fire 141-141-	f 4)		Ce	runcate or i	Dealli	2. Date of D		2000	
	Physicia	an	Decedent's Name	(FIFST, MIDDIE,	Last)					Month	Day		3. Time of Death 3:00 A M
	/Medic		Mary Jan							August			
	Examin	er	4a. Facility Name (If					4b. City, Town, or		eath		County of Death	
			Aspenwoo  5. Social Security No		r Living		munity (In yrs. last birthday)	Silver	Spring If Under 24 F	Irs. 8. Date of B		ontgome	ry place (State or Foreign
П	Funeral		218-09-3		. 50x 1 ☐ M 2 🔀 F	91	Yrs. last birthday)	Months Days		lin. (Month, D	ay, Year)	Cor	intry)
	Director		Usual Residence of	Decedent						May 1	,191	5 S. C	Carolina
	land ow		10a. State	10b. County			IOc. City, Town or Lo	ocation					10d. Inside City Limits
	Man,	to	MD	Montgom	ery		Silver S	Spring					1  Yes 2 □ No
	28a	Director	10e. Street and Nurr	nber				10f. Zip Code			10g. Citi	izen of What Cor	untry?
	3a o		14400 Ho	mecrest	Road A	nt.#3	17	20906				USA	
	me 2	Funeral	11. Maritat Status		12. Was De	cedent Ev	er in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or N		14. Race - Amer	
٥	after or ite	Ē	1 Never Marrie	_		2€ No		If Yes, specify Cuba		ieno Hican, etc.)		Black, White	
215-0036	be filed within 72 hours after deeth with the Maryland hat lygiene. d other than "natural", or iteme 23e or 28e-f ahow event. The Medical Exatr an must be notified at	l by	3X Widowed	4 Divorced	If Yes, G Year or	Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specify: Wh	ite
ດ້	72 h natu	Completed	(Speci	15. Decedent's	Education grade completed	)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of t	working	16b. Ki	ind of Business/I	ndustry
2	han han	id	Elementary/Secon	ndary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired	1)		_		
2	filed w Hygie other ti		12	Fire Middle 1			Sec	cretary	10 14-15-1-1	Name (First, Middl	_	w Firm	
ב	be fi	Be	17. Father's Name (		- 1								
<u>₹</u>	nould be d Mental narked o	James Rivers Crosswell  19a. Informant's Name/Relationship (Type, Print)  George Lemm / Son  40900 Snickersville Turnpike Audie, VA  20a. Method of Disposition  1 Thuring 2 Cromation 3 Removal from State  1 Thuring 2 Cromation 3 Removal from State  20b. Place of Disposition (Name of cometery, crematory or other place)											
Maryland	12 st h and 7 ts u		George Le	·	Son			Snickers			-		0105
	1 and Heelt am 2 ther		20a. Method of Disp		5011					Date	-	ocation - City or 1	
Baltimore,	Pages Int: If it		1 Burial 2	Cremation 3	☐Removal from	n State	20b. Place of Dispo cemetery, cre						
	rtmer rtant			5 Other (Spe			Ft. Linco	oin Cemete  2. Name and Addres	-				
ga	permit. Pages Department of t important: If it any injury or or once.		21. Signature of Fu		gton, Do								
			222 Part Enter II	sty 14	LIMOUS that	caused th						gton, De	Approximate
					nly one cause on	each line	ne death. Do not en	rei the mode of dyni	g, such as care	Jiac or respiratory	arrest,		Interval Between Onset and Death
	Physician		tmmediate Cause ( disease or condition resulting in death)		a			noma					1 day
	Examiner	/Medical resulting in death)  Due to (or as a consequence of):											1
		70	Sequentially list cor	nditions,	b. — Oua fo	for an a	nonsecuanna afil						
	ted nsit	Examiner	Sequentially list cor lary, leading to in cause. Enter Under Cause (Disease or	rlying injury		(							
	al-tra	Xar	that initiated events resulting in death) L		c. Due to	o (or as a	consequence of):						
8760	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicai E			4								
89	ficate p phy is the	edic			u.								
Box	eath certific ettending p I for use as	<b>№</b>	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, o							23d. Date of deli	very
ň	d for	by Physician/Me	in the past 12,	months?	4 ☐ Preg	gnant at tie		□Ectopic pregnancy □ Other (s <i>pecify</i> )				Month	Day Year
o	at the de by the o	hys	9 Unknown		9□ Unk	nown			55,042				
a.	w requires that been signed b should be deta	y P	Part II. Other signifi	icant condition	s contributing to	death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
<u>8</u>	quire n sig uld b	De la		5h	relce					_ 10	Yes 2	⊠No 3⊟Pro	babiy 4 Unknown
ပ္ပ	s bee	jet		Air	cal	telo	ullab			24a. Wa		24b. Were aut	opsy findings available
Ÿ	sician: The law s certificate has b lirector, page 2 s	Completed				0	<u> </u>			per	opsy formed?	death?	ompletion of cause of
Vital Records,		0	25. Was case referr	ed to medical	-				26 Place of [	1 ☐ Yes Death Check only		1 ☐ Yes	2□No Assisted
	ysicia s cer direct	To B	examiner? 1 ☐ Yes 2 <del>√</del> 2x		Hospital:	] Inpatient	2 ER/Outpatie	nt 3 DOA Oth	00	g Home 5 ☐ Res		6 ⊠Other (Spec	
Division of	ng Phys fter this neral di		27. Manner of Death	1	-	of Injury				28d. Describe			
0	ttending death. ctor: After y the funer	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investiga		mm, Day	Year) Injury		k? Yes 2 ∐No				
<u>N</u>	Atte	ill c	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	286. Plac	e of Injun	y - At home, farm, st	reet, factory, office			(Street an		ral Route Number,
5	s after s afte	Certification:	4 El Homoldo		- Juli	dirig, etc.	(Spacity)			Only or 7.	omi, Siale	,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director,		23t Cartifier (Check only	1   Marting	Physician: To the	ta bast of	my knewledge, deat xamination and/or in	f uccumed at the tite	ra, date and pla	and and Sua to the	causa(s)	and manner as	tialed.
	in 24 the Fi	Medical	one)		and ma	nner state	ed.			course at the time			
	To the within 2 To the comple	Σ	29b. Signature and	title of certifier		1		29c. Licens	9 number 38262	ļ		te signed (Month $$ t 25, 2(	· ·
	6			Mn	cee	R	lengh	ND DS	,0202	Í	ugus	L 4.J, 21	,00
	-	18					ith (Item 23a) (Type,						
			Anurita M					ch Blvd.	#330 R	ockville,	MD	20850	i.d
	Sta		31. Date filed (Mont		2006	Registrar	's Signature	whe					
	Registr	ar	Al	JG 28	2000	A COLOR	is so						

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 08 Physician 2006 10:06 pm Andrew Edward /Medical Lynton 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery
9. Birthplace (State or Foreign Bethesda Year It Under 24 Hrs. 8. Date of Birth Month Day 1981 04/12/1949 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 127-36-7330 1 → M 2 □ F 57 New York Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits •how permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Department: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show impring to other treumatic event, it a Medical Examinar must be notified at once. 1 ☐ Yes 2 ☐ No NYManhattan Manhattan Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 120 E. 31st Street 10016 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Lynton ည Edith Schoenberg 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Lynton/ Brother 4207 37th Street NW Washington, DC 20008 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Choices 08/29/06 Chantilly, VA 22. Name and Address of Facility Old Town Funeral Choices 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, out-implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alexandria, Va 22307 Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) 20016 **Physician** JHEROSC /Medical Due to (or as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Petat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate 2□ No 1 Tyes 25. Was case referred to medical exampler? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 2 No After thi 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accide 5 Pending death. 1 ☐ Yes 2 ☐ No Accident To the Funeral Director; , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wan ne and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda, MD William B. Swann MD 8600 Old Georgetown Road 31. Date tited (Month, Day, Year) 32 Registrar's Signature State AUG 28 Registrar

8/22/06

LYNTON, ANDREW

			1 - For Amend Item 27 Registrar	State of Man	859,09/	12/06d Certifica	nt of He hb te of D	ealth and Death			006	
	Physici /Medic		Decedent's Name (First, Middle, Last)	William	Michae	l Lloy	đ		2. Date of De Month Septem	Day	Year 2006	3. Time of Death  6:20 A M
	Examir Funeral Director		4a. Facility Name (If not institution, give s  11733 Snug Harbor  5. Social Security Number  214-28-6491	Lane	n yrs. last birth		Will er 1 Year	liamspoil Under 24 Hrs Hours Min.	s. Date of Bi	Th.	Vashino 9. Birthpl Count	
:	ס		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location			APITI	10,1001		0d. Inside City Limits
-	or 28a-f	Directo	Maryland Washingto	on			<i>Willia</i> ip Code	amsport		10g. Citizen o	I What Coun	1 ☐ Yes 2X No try?
9	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Items 23a or 28a-f ehow event, I'rs Madical Exeminar must be notified at	Funeral	11733 Snug Harbor  11. Marital Status  1 Never Married X Married	Lane 12. Was Decedent Eve Armed Forces? 1 □ Yes 2X No If Yes, Give	r in U.S.	13. Was Dec			Specify Yes or No to Rican, etc.)		ace - America lack, White, e	etc.
21215-0036	in 72 hours n "naturel", lodical Exa	Completed by	3 Widowed 4 Divorced  15. Decedent's Educe (Specify only highest grade)	Year or Dates: cation a completed)	1	Decedent's Us	ual Occupat		rking	16b. Kind of	. WI.	ite dustry
	m - 0 5	Be Comp	Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	C	orrect		Office1 18. Mother's Na	me (First, Middle			l Institute
Maryland	2 should the and Ment le marked aumatic e	To	William J. Lloyd  19a. Informant's Name/Relationship (Ty,	pe, Print)	19b.	Mailing Addre	ss (Street ar		e Mannin ural Route Numb	-	n, State, Zip	Code)
altimore, N	permit. Pages 1 and 2 should be Department of Health and Monta Important: It item 27 is marked any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and any njury or other traumatic and not not not not not not not not not not		20a. Method of Disposition  1 Burial 2 Tremation 3 R	emoval from State	20b. Place of I cemetery	Disposition (N. crematory or	ame of other place,	Sept	ember 3	20c. Location	n - City or To	
Baltin	permit. Pa Departmen Important any njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Smithsb Mol4/4	22. Name :	and Address	of Facility		. Davis	Funer	Maryland cal Home and 21783
7	Physician /Medical Examiner	-	20a. Fart 1. Enter the disease, or complishock, or heart lailure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  A. A. COTE  Due to (or as a company)	death. Do no	JR# 76	ode of dying,	such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	):			<b></b>			7-115
P.O. Box 68	law requires that the death certifica as been signed by the attending ph . 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (					Date of delive Month	ory Day Year
	w requires that been signed b should be deta	٤	Part II. Other significant conditions con		ot resulting in		cause giver	n in Part I.		tobacco use co Yes 2 ☐ No		ably 4 Unknown
II Recc	The ate h page	Completed			-				24a. Was auto perfi 1 🗆 Yes	opsy ormed?	bere autor frior to con death? 1 \( \text{Yes} \)	psy findings available inpletion of cause of
of Vita	Physician: Th r this certificate iral director, pag	To Be	25. Was case referred to mertical examiner? 1  Yes 2  Ho	lospital: 1 Inpatient 28a. Date of Injury	28b. Ti		Other	4 ☐ Nursing I	ath Check only Home 5 4 s 28d. Describe			•)
Division of Vital Records,	To the Hospital or "Itanding Ph within 24 hours atle death. To the Funeral Director: Aller th completely filled in by the funeral	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day You 28e. Place of Injury building, etc. (:	- At home, far	m, street, lacto	1 🗆 Yı	? es 2 □No	28I. Location City or To	(Street and Nur own, State)	nber or Rura.	l Route Number,
	Hospital     24 hours a     Funeral Eletely filled	edical Ce	29a. Certifier 1 Dertifying Physical (Check only one) 2 Medical Examination	sicien: To the best of ner: On the basis of example and manner stated	amination and	death occurre for investigation	d at the time on, in my opi	e, date and plac nion, death occ	e, and due to the urred at the time	cause(s) and r , date and place	manner as st e, and due to	ated.
t	To the within 2 To the Complet	Me	29b. Signature and title of certifier	/_ 5	~		9c. License	number		29d. Date sign	ned (Month, L	
	5		30. Name and address of person who co			ype, Print)			מ עונד	- •		
	Sta Regist		31. Date liled (Month, Day, Year) SFP 1 2 2006	32. Registrar's	Signature	3	170	7 0010	rown, n			

			Piease I  1 - State Registrar	State of Marylar			t of Health and I e of Death		iene 2001 iene 2001	5 28945
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  CHRISTINE	MTCHEL	- 2_			2. Date of Deat Month	h Day Year	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give s UNIVERSITY OF MARY	treet and number)		00.	Town, or Location of Death	ו	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 226–46–9667				1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, August	Year) 9. Bi	nthplace (State or Foreign ountry) irginia
	Maryland f ehow	ior	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince 6		ty, Town or Lo		ights			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28e-	Funeral Director	10e. Street and Number 2511 Millvale Av			10f. Zip		1	Og. Citizen of What C United S	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or iteme 23a or 28e-f ehow or other traumatic event. The Madical Examinar must be notified at	<u>م</u>	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	i		dent of Hispanic Origin? (S cify Cuban, Mexican, Puerl 2凶 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	hin 72 ho a. an "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupation rk done during most of wor se retired)	king	16b. Kind of Business	s/Industry
2	d wit	PO	9th	,	Homem	aker			Domesti	С
Maryland	uid be file Mental Hyl rked other ific event.	To Be C	17. Father's Name (First, Middle, Last)  Jake White				18. Mother's Nar Bessie	ne <i>(First, Middle, M</i> Grigsk		
, Mary	and 2 sho laith and 1 n 27 is ma er trauma		19a Informant's Name/Relationship (Type Bessie Mitchell/Da	ughter	3801 Blad	Keni	(Street and Number or Rules 1	ral Route Number S Kenil 10	City or Town, State, Worth Aven	Zip Code) iUe
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is eny injury or other tra <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo	osition (Nar	ne of	Date :	20c. Location - City o	Town, State
Balt	Departit Departit Importe eny inju		21. Signature of Furreral Service License	Tikell	2:	2. Name an		ope Fune 538 Mari orestvil	ral Homes boro Pike le, Md. 2	0747
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. Liet only on Immediate Cause (Final disease or condition resulting in death)				arction arction arction arction		est,	Approximate Interval Between Onset and Death
3760,	death certificate be executed e attending physicien and of for use as the burial-transit	Ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	Mell	tus			
P.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3[	⊒Ectopic pr ⊒ Other (sp			23d. Date of de Month	olivery Day Year
	9 5 B	۵	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying c	ause given in Part I.			o the cause of death?
of Vital Records,	ysicien: The faw requir is certificete has been si director, page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
₹	cien ertifi ector	Be	25. Was case referred to medical examiner?				1 -	th Check only on	9)	
=	Physicien: rthis certifice ral director, I	၉	110(162 20 NO		ER/Outpatie			ome 5 Reside	nce 6 Other (Spe	ecify)
Division c	tending Pleath.	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	М	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho		
Div	To the Hospital or Attending lawihin 24 hours after death. To the Funerel Director: After Smpletely filled in by the funer		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town		
	To the Hosp within 24 hou To the Fune Empletely fi	Medical	(Check only 2 Medical Examir one)	icien: To the best of my kn er: On the basis of examin- and manner stated.	owledge, deat ation and/or in	ivestigation	, in my opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	F 3 F 0	2	29b. Signature and title of certifier	Y	1-20	1	: License number 14176435 Al	1	9d. Date signed ( <i>Mon</i>	th, Day, Year)
ė:	6			OH TALKEL	OPK F	Print)	3C PAIS		MD 211	444
t	Sta Registi	ate rar	SEP 0 1 2006	32. Registrar's Sign	ature					,

State of Maryland / Department of Health and Mental Hygiene 2006 28946 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 22, 2006 Year **Physician** 3:45 P Mitchell Amelia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Manchester Long View Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01 / 10 / 19 19 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TXF Pennsylvania 87 Director 219-12-4583 Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked othar than "natural", or itema 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "natural", or itema 23a or 28a-1 show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Edgewater Marvland | Anne Arunel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21037 1413 Central Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Self Employed Beautican 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hartzell Edgar Samue1 Mav Myers Aurea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If Item 27 is any injury or other traugure. 2563 Ebbvale Road, Manchester, Maryland 21102 Robert J. Simpson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/23/06 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of meral Service Ligensee George P. Kalas Funeral Home, P.A. alex 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final anurance Conces **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, tany, leaving to infine class cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1□ Yes 1 Tyes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 3□ DOA ۴ this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: 1 Atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funaral Di 29a. Certifier 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mule D47683 8/23/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21136 Miller Main Strus Rustestews Raymond 37 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2006 Registrar

			For Stete Registrer	State of Ma	aryland		artment of				ene g. No.	2006	2894
	X.		Decedent's Name (First, Middle	, Last)						. Date of Death Month			3. Time of Death
ų.	Physici /Medio		Phyllis M. Mi							Aug.	23,	2006	0227 м
	Examin	ner	4a. Fecility Name (If not institution) Anne Arundel I		or		4b. City, Town,	or Location on nnapol				ounty of Death Anne Ar	andol
	Funeral				e (In yrs. las	st birthday)	If Under 1 Yea	r If Under	24 Hrs.   8	. Date of Birth	L		place (State or Foreign
l	Director		138-24-7685	1 ☐ M 2 <b>X</b> ) F	76	Yrs.	Months Days	Hours	Min.	(Month, Day, OV. 2,	1929	Cour	NJ
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Maryl I sho	ţō	MD Anne	Arundel			Annapo	lis					1 ☐ Yes 2 No
	or 28s	Director	10e. Street and Number				10f. Zip Code			10	g. Citizer	of What Cour	ntry?
	e 23e		800 Bestgate I					1401			1	USA	
036	be filed within 72 hours after deeth with the Maryland nat Hygiene. ed other then "natural", or teme 23e or 28e-1 show event, the Madical Examinal must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 🎖 Widowed 4 □ Divorced	ied 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of f Yes, specify Cu □ Yes 2X No			ty Yes or No- can, etc.)		Race - Americ Black, White, pecify: Whi	etc.
ئ ص	72 ho	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  Manager								1	6b. Kind	of Business/Inc	dustry
21215-0036	within ene. then										Olde	Towne	Cleaners
-	e filed with	0	17. Father's Name (First, Middle, I	Last)			- I AM ANGE	18. Mothe	er's Name (F	First, Middle, M			
ylar	2 should be and Mental Is marked o	To B	Ansylm Biemul	ler				Rut	h Pat	ton			
Maryland	12 sho		19a. Informant's Name/Relationsh				g Address (Stree						
e,	1 and Health tem 2:		Cynthia Toft/Da 20a. Method of Disposition	augnter	20b. Plac	ce of Dispo	2 Muddy sition (Name of	1	ROad,			ion - City or To	
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked eny Injury or other traumatic es		1 XBurial 2 Cremation 4 Donation 5 Other (Sp	_	сеп	netery, cren	atory or other pl	· · · · · · · · · · · · · · · · · · ·	Aug.	28,			
<u>=</u>	partm portal y Inju		21. Signature of Funeral Service I			22	. Name and Add	ess of Facilit	ty	2006 —		wnsvill	
n	89 E 2 8		Thomas?	All		49	95 Gov.	Ritchi	e Hwy	, Sever	na P	ark fur ark, M	
			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	10.			ing, such as	cardiac or re	espiratory arres	st,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Age	TIC	>Τ Ε.	vosis						
	Examiner			P~ €~								-	TWELK
	g	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a									
_	and II-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a conseque	nce of):						-	
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٥	ng phy as th	Medi	IF FEMALE:										
. Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal de	eath 3	Ectopic pregnand Other (specify)	су			23d	. Date of delive Month	Day Year
<u>т</u> Э	at the	Phys	9 □ Unknown	9□ Unknown									
Hecords,	The law requires that the death certify lie has been signed by the attending bage 2 should be detached for use as	sted by	Part II. Other significant condition	ns contributing to death bu	it not resulti	ing in the ur	ideriying cause g	iven in Part I.	· 	1 Tes	100		ably 4 Unknown
al Kec	The lay ate has page 2	Completed								24a. Was an autopsy perform	2 50? 5No	4b. Were autoperior to condeath? 1 Yes	psy findings available inpletion of cause of
VIII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 Inpatier	0 CE	NOutpatien	3 DOA	hor		Check only one		1011 10 1	
ō	ig Phy ter this neral o	n: To	27. Manner of Death	28a. Date of Injur	y 28	8b. Time of Injury	28c. Inju			5 Residen  1. Describe how			<u>')</u>
UNISION	tendir eath. or: Af the fur	catic	↑ Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation		,		Yes 2 1	No				
5	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of Inju building, etc	ry - At home: (Specify)	e, farm, stre	et, factory, office		28f.	Location (Stre City or Town,	et and N State)	umber or Rura	l Route Number,
	To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifyin	g Physician: To the heat o	if my knowle	ndge, death	occurred at the t	ime, date an	d plane, and	I due to the cau	es(e) and	d manner as et	ated.
	the Ho iin 24 the Fu	Medical	one)	examiner: On the basis of and manner sta	examination	n and/or inv	estigation, in my	opinion, deal	th occurred	at the time, dat	e and pla	ice, and due to	the cause(s)
)	Mith To Com	2	29b. Signature and title of certifier					se number	7_	290	a	gned (Month, I	Day, Year)
7			30. Name and address of person v	who completed cause of di	ath (Itom 3	3a) (Tuno 1			•		8/1	23/6	
	5			7 HCHELL			42040E	C 00 50	SICH	CE 250	2		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	A A	book						
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State of Maryland / Department of Health and Mental Hygiene 2006 For State Registra 28948 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month **Physician** August 23, 2006 11:20 PM Hans R. Mendhiratta /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Montgomery Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1(XM 2□F 01/01/1926 80 India 214-23-5113 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Modical Examinar must be incitified at 1 Yes 2 □ No Director Maryland Montgomery Darnestown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20874 14001 Hartley Hall Place Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Itam 27 is marked other that any injury or other trauments. Retail Clothing 5 Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pyari Bai Bhalla Ganesh Mendhiratta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14001 Hartley Hall Place Darnestown, MD 20874 Arjun Mendhiratta/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Northern
Virginia Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/26/2006 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached in 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown 1 Tyes 2 X No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No this certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospice 1 Yes 2 X No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident filled in by the Diractor 6 Could not be 28e. Place of trijury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after To the Hospitel o within 24 hours at To the Funeral DI 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · Cynthiam Dilliams H0058032 08/25/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Montgomery Hospice 6001 Muncaster Mill Rd. Rockville, MD D.O. Cynthia M. Williams, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 2 5 2006 Registrar

			For State Registrar	State of	f Marylar		artment of H	Health and I Death	Mental Hy	giene Reg. No. 20 (	06 28949
			Decedent's Name (First, Middle, L.)	ast)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Sylvia Jean McKi	nney					Month August	27, 2006	12:25 A <sup>M</sup>
	Examin		4a. Facility Neme (If not institution, g		nber)		4b. City, Town, o	or Location of Deat		4c. County of	
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	Funeral Director		5. Social Security Number 220-50-5705	Sex 1 □ M 2 <del>  X</del> F	7. Age ( <i>In yr</i> s. 57	Yrs.	Months Days	Hours Min.	March 2	Y Year o / o	Birthplace (State or Foreign Country) Vest Virginia
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty. Town or Lo	cation				10d. Inside City Limits
	Aaryia f ehor	ō	Maryland Washing	eton		Cascad					1 ☐ Yes 2√2 No
	the N	Director	10e. Street and Number	5011		Cascau	10f. Zip Code			10g. Citizen of Wha	at Country?
	h with	ai Di	25439 Warren Ave	nue			21119		1	United St	•
	ems :	Funerai I	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert			American Indian, White, etc.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or items 23a or 28a-f ehow aumatic event, the Madical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		2⊠No e		1 ☐ Yes 2 kkNo	Specify:	,	Specify:	
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215	thin 7:	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Real Estate Agent  Realty									,
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and	~ ~ 0 =	Be	17. Father's Name (First, Middle, Last (unobtainable)	st)						Maiden Sumame)	
<u> </u>	hould id Mei mark matic	ဥ	19a. Informant's Name/Relationship	(Type Print)		19b Mailir	og Address /Street		(unobtai	nab⊥e) er, City or Town, Sta	ute Zin Code)
<u>8</u>	nd 2 s lith an 27 is r frau		Barry Rines / So			1		Ave. Caso			ne, 21p 000e)
Baltimore, Maryland	es 1 a of Hea fitern r othe	***************************************	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Ramoval from S	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other place naven	ce) A11011	Date st 30,	20c. Location · Cit	y or Town, State
Ĕ	Pag tment tent: I		4 ☐ Donation 5 ☐ Other (Spec	city)			Cardens			rederick,	Maryland
Ball	permit. Pages 1 and 2 should be Department of Health and Menta importent: if item 27 is marked eny injury or other traumatic ex		21. Signature of Funeral Service Lie	nsee		R	Name and Address thaven	Funeral	Services	, Skkot (	Cody P.A.
			23a. Part1. Enter the disease or to shock, or heart failure. Vist on	mplications that ca	aused the deat	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	ederick,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	- M	or as a conseq						months
	Examine	ē	Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying	b. Flora and	or as a nonsec	userca offi					
	uted 1 Insit	mine	cause. Enter Underlying Cause (Disease or injury that initiated events	54047	or dis di dioi isolo	was rod ory					
ó	exect en and rial-tra	Examine	resulting in death) Last	Due to (	or as a conseq	juence of):					
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9 ×	eath certific ettending p for use as	/Me	IF FEMALE:	23c. If yes, outo	come of pregna	ancv				224 Date o	I deliane
Box	death e etter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1⊡Live bi 4⊡Pregna	irth 2∏ Feta ant at time old	Ideath 3	Ectopic pregnancy Other (specify)	4		23d. Date o Month	Day Year
J.	that the de ned by the e detached f	hys	9 🗆 Unknown	9□ Unkno							
Vital Records, F	8 50	þ	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?  ☐ Probably 4x3tUnknown
င္တ	aw require s been si 2 should t	Completed							24a. Was		re autopsy lindings available
ž	9 - 2	mo								rmed? dear	r to completion of cause of th? Yes 2 \sum No
Ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						ith (Check only o		
<b>=</b>	hys his	2	1 ☐ Yes 2 🔀 No			ER/Outpatier		4 🗆 Nursing n		dence 6 Other (	Specify)
0	ding Ph h. After th funeral	tion	27. Manner of Death  1. SNatural 5 ☐ Pending 2 ☐ Accident investigati		h, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 ∐No	28d. Describe h	now injury occurred	
Division	Atten r deat ector: by the	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	ol Injury - At he	ome, larm, str	eet, factory, office				or Rural Route Number,
ā	itel or At irs after o rai Direct led in by	Cert	4   Northcide	bullair	ng, etc. (Specif	y) 			City or Tow	vn, State)	
	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	edicai	29a. Certifier 1 □ Certifying F (Check only one) 2 □ Medical Ext	Physician: To the aminer: On the ba and mann	isis of examina	owledge, death trion and/or in	occurred at the tire restigation, in my o	me, date and place ppinion, death occu	, and due to the or rred at the time, o	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier		MM	6-	29c. Licens	e number		29d. Date signed (M	Month, Day, Year)
	0		P	1/0	1	/		1786		August 2	28, 2006
	5		30. Name and address of person who					2022	MD 217/	4.2	
8	Sta	te	J. Allen Cherry, 31. Date liled (Month, Day, Year)	2006 32.	egistrar's Signa	ature	ave., nas	gerstown,	MD 21/2	+∠	
	Registr		AUG 2 9	ZUUD	new ,	C. 19					

State of Maryland / Department of Health and Mental Hygiene 2005 28950 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Month 10:02 Am Robert Thomas Mitrecic 8 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 713 Laurel Ave. Ocean City
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/4/1944 Birthplace (State or Foreign Country) **Funeral** 1 2 M 2 □ F Director 193-34-1060 62 PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits other then "nature!', or items 23a or 28a-f ehovent, tre Medical Examiner must be notified at 1 1 Yes 2 No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Laurel 21842 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Home Improvement permit. Peges 1 and 2 should be filed Depertment of Health and Mental Hyg Important: if tem 27 ie marked other eny injury or other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Mitrecic, Sr. Bertha Dauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Vaile Mitrecic (wife) 713 Laurel Ave., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 8/28/2006 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complications that a used shock, or heart ailure. List on the cause on each in he death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLONA Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Jinknown this certificete hes been si al director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 202 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

Jerrold S. Canakis, MD., P.A. 124 N. Main Street Berlin, MD 21811 3. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		aryland / Department of Health and N 360,10/10/96/11/11/16/21/19	
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Myrtle Marie Myers		2. Date of Death Month 8/31/06 Pay Yeer 3. Time of Death 10:15 PM
Examiner Funeral Director	4a. Fecility Name (If not institution, give street and number)  OAK(and NumSing 9)  5. Social Security Number 6. Sex 17. Ag  362-36-1706 1 M 2X) F	4b. City, Town, or Location of Death  Oal Can  le (In yrs. last birthday)  69 Yrs.  Wonths Days Hours Min.	4c. County of Death  8. Date of Birth (Month, Day, Year) 5/28/1937  9. Birthplace (State or Foreign Country) Alabama
show d.st	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
oeam with the maryland ms 23e or 28e-f show trivist be finitified at neral Director	MD Garrett  10e. Street and Number  873 Silver Knob Road	0&kland 10f. Zip Code 21550	1 ☐ Yes 2X No  10g. Citizen of What Country?  USA
ene. than "natural; or items 23a or 28a-f show ite Madical Extra intermust be rutified at ompleted by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces? 1 Yes 2 Married 1 Yes, Give Year or Dates:	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - American Indian.
ygiene. nar than "natura t, the Modical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Home Maker	16b Kind of Business/Industry
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II = M. once.  To Be Compl	17. Father's Name (First, Middle, Last)  John Calvin Norswor		e (First, Middle, Maiden Sumame)  Norris
in 27 is ma	19a. Informant's Name/Relationship (Type, Print)  Ronald O. Myers/ Spouse  20a. Method of Disposition	19b. Mailing Address (Street and Number or Rur 873 Silver Knob Rd.,	Oakland, MD 21550
ortant: If its ortant: If its injury or of	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Cremation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	20b. Place of Disposition (Name of cemetery, crematory or other place)  Rose Hill Cemetery 9/4  22. Name and Address of Facility St	/06 Thomas, WV
any ir	Beeleystan	32 S. Second St.,	Oakland, MD 21550
been signed by the attending physician and should be detached for use as the burial-transit and properties and by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):  a consequence of):	yew3
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
ed by Pl	Part II. Dther significant conditions contributing to death b	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes MNo 3 Probably 4 Unknown
r, page 2			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No
H a L	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Da 2 Accident investigation	ent 2 ER/Outpatient 3 DOA Other:	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
filled in by th	4 Homicide Selection building, et	c. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
completely filled in by the funer  Medical Certification:	29a. Certifier Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and manner state.  29b. Signature and title of certifier	of my knowledge, death occurred at the time, date and place, if examination and/or investigation, in my opinion, death occurrated.  29c. License number	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
(0	30. Name and address of person who completed cause of d	Jeath (Item 23a) (Type, Print)  SANO (FIRE Device)	11/06 Saldand WXD 21000
State Registrar	31. Date filed (Month, Day, Year) 32. Registro	ar's Signature	

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		1- For State Registrar	ate of Maryland /		cate of Dea			Reg No	200	06 2895
Physicia	ın/	1. Decedent's Name (First, Middl					2. Date of De Month		Year	3. Time of Death
lical Examir	ner	Colin Lamar M  4a. Facility Name (if not institutio			145 030	Tarra and another	August 1	4, 2006		1831 hrs
		Peninsula Regional M	,			Town, or Location	or Death		ounty of Deat	n
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last b	irthday) If Un	der 1 Year If Und	er 24Hrs. 8. Date of E	lirth(MM/DD/	YYYY) 9. Bi	rthplace (State or gn Washingtor
Director		214-42-7194	1 X M 2 F		63 Yrs. Mon	hs Days Hour		26, 1		<sub>gn</sub> wasningtor <sup>Duntry)</sup> DC
<b>a</b>	1	Usual Residence of Decedent				1 (				
ow any		10a. State 10b. County		10c. City, Tow						10d. Inside City Limits  1 Yes 2 XNo
ryland a-f sho t once	ģ	Virginia Acc	omack	Gree	nbackvil:	Le p Code		10a Citizen	of What Cou	
vith the Maryland s 23a or 28a-f show a pointed at once.	Director	2598 Buccane	er Blvd.		100.2	23356		Tog Chizen	USA	•
D <b>71215-0036</b> should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent	Ever in U.S.		lent of Hispanic Ori	gin? ( Specify Yes or N	lo- 14.		ican Indian, Black,
or items	Funeral	1 Never Married 2 Ma	1 Yes 2	X No	If Yes, spec	ofy Cuban, Mexicar	, Puerto Rican, etc.)	-	White, etc.	
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hour hatu	ted	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or 5			l Occupation (Give orking life. DO NOT		16b. Kind	of Business/	Industry
hin 72 thin 72 than than	Completed	12	College (1 4 of c	,	~				_	
ZIZIS-0030 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	S	17. Father's Name (First, Middle,	Last)		Gunsm		's Name (First, Middle	Sel Maiden Sur	<b>f — Empl</b> name)	oyed
be fill ental H arked	8	Colin Lamar M:					Marv_Wi	lson	Anezes	
should and Manatice	입	19a. Informant's Name/Relations		1	9b. Mailing Addres	s (Street and Nur	nber or Rural Foute Nu	ımber, City o	r Town, State	e, Zip Code)
and 2 sho ealth and em 27 is traumati	-	Robert R. Micha 20a Method of Disposition	el/ Brother	20b. Place	8921 Bri	nk Road,	Gaithersbu	rg M	D 2088	2 Town State
DatiumOre, MD Z LZ 13-00-30 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other transmatic event, the Medical Examiner			3 Removal from Sta	ite crem	atory or other place Lincoln Ce	9)		1		
baltimore, permit. Pages I am Department of Heal Important: If iten injury or other tra		4 Donation 5 Other Sp. 21. Signature of Funeral Service		FOIC		2	2006			ood, Maryla
Dail		Asmes CC	landa.		Franc	is J. Col	lins Funer	al Hor	me Inc	ng, MD 2090
Physician		23a. P. rt I. Enter the disease, or fa ure. List only one cause	complications that caused	the death. Do	not enter the mode	of dying, such as	cardiac or respiratory a	rrest, shock,	or heart	Approximate Interval
/Medical Examiner	1	Immediate Cause (Final disease	a Multiple Injuries							Between Onset and Death
		or condition resulting in death)	Due to (or as a conse	quence of):						
,	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C				<del>_</del>			
ted 1 Innsit		events resulting in death) Last	Due to (or as a conse	quence of):						
e executed cian and rial - transit	ical	UNPENDED	AMENDED							
ate be	Med	IF FEMALE:	23c. If yes, outcom	ne of pregnanc	у			23d D	ate of deliver	<u> </u>
UIVISION Of VITAI RECORDS, P.O. BOX 68/60, within 24 hours after death certificate be within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	I LIVE DITTI	time of death	2 Fetal death	3 Ectopi	c pregnancy	Мо		Day Year
e atten	/sic	1 Yes 2 No 9 Unk	nown 9 Unknown	time of death	5 Other (Sp	ecify)				
by the		Part II. Other significant conditi	ons contributing to death	but not result	ing in the underlyir	g cause given in P	art I 23e. Did	tobacco use	contribute to	the cause of death?
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DIVISION Of VITAI KECOFGS, to are A treatment of the treatment of the feath all Director: After this certificate has been siled in by the funeral director, page 2 should be a treatment of the funeral director.	Completed						24a Was			topsy findings available
eco he law ate has	m o							ormed?	death?	
an: T	BeC	25. Was case referred to medical				26.Place of Death				
VIE hysici this co	୍ଠା	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 ER/	Outpatient 3	DOA Other	Nursing Home 5	Residence	6 Othe	r:
After	Ë.	27. Manner of Death  1 Natural 5 Person	28a Date of Injui (Month, Day Ye Aug 14, 2006	ry 28b	o. Time of Injury 59 hrs	28c. Injury at Worl	Driver of a			
Attend death death sector:	catio	J Perio	stigation			1 Yes 2				
DIVIS Spital or A hours after meral Dire y filled in b	Certification:	deter	d not be mined (Specify) stre		tarm, street, factor	y, office building, e	or Town,	State)		ral Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page		4 Homicide 29a. Certifier 1 Certifying Pt	nysician: To the best of my		eath occurred at th	e time, date and n	Snow Hill F			
To the Hos within 24 h To the Fur	Medical		miner:On the basis of exan							
with Cor	Me	29b. Signature and title of certifie	and manner stated,	•	29	c. License number		29d Date	signed (Mo	nth, Day, Year)
5		Pot ()	-12001			O.C.M.E.		August	15, 2006	
7		30. Name and address of person	· ·	,	•					
		Patricia Aronica-Pollal 31. Date filed (Month, Day, Year)	-	edical Exa	miner 111 F	Penn Street, Ba	altimore, MD 2120	01		
			32 Registrar							

			1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	artmen rtificat	t of Healt e of Dea	h and M		Reg. No.		
	Physici /Medic		Decedent's Name (First, Middle, La.  Mary Esther	•					2. Date of Di Month AUGUST	eath Day		3. Time of Death  12:20P.M. <sup>M</sup>
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	D	ctor	Usual Residence of Decedent 10a. State 10b. County  Maryland Washir		: City, Town or Lo	ocation gersto	own		Dec 1	2 191	2 Wes	st Virginia  10d. Inside City Limits  1X Yes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 503 Washington S	Square		10f. Zip		1740		10g. Cit	U.S.A	
900	be filed within 72 hours after deeth with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28a-f ehow event, the Medical Exartinar must be rectified at	ᅙ	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	1	Was Deced If Yes, spec	dent of Hispanic cify Cuban, Mex 2X No Spe		ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: V	
21215-0036	filed within 72 h Hygiene. other than "natu ent, tre Medical	Completed	15. Decedent's Education (Specify only highest grade) Elementary/Secondary (0-12)		(Give			most of worki	ing		ind of Business	
Maryland 2	2 should be filed and Mental Hyg is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last, Harry W. Michael					Emma	(First, Middle	da Ca	in	
	and 2 lealth a om 27 is		19a. Informant's Name/Relationship ( Donna J. Gossard  20a. Method of Disposition	(daughter)		25 Ove	erbrook	Rd. Ha		own M	or Town, State, . laryland ocation - City or	21740
Baltimore,	permit. Pages Department of Himportant: If its eny injury or of page.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentary)	y)	Cedar La	AWN Me 2. Name an	em Park	acility Do	uglas A	. Fi	ery Fur	n Maryland neral Home aryland 21742
8760,	bhysician and hysician and the buriar-transit the b	lical Examiner	23a. Part1. Enter the disease, or com shock, or he at failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	facture of):  Letter  Assequence of):							Approximate Interval Between Onset and Death
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pr ⊒ Other (sp					23d. Date of de Month	livery Day Year
	w requires that i been signed by should be deta	ğ	Part II. Other significant conditions of		_		_					o the cause of death?
Il Records,	Physicien: The law re this certificate has bee al director, page 2 sho	Completed	Arteris Scher	nean					24a. Was auto perf 1 \( \text{Yes}	psy ormed?	24b. Were an prior to death?	utopsy findings available completion of cause of
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of	ding Phys h. After this funeral dir	tlon: To	1 Yes 2 WNo  27. Manner of Death 1 Watural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		OA Carrell 4 (2) 28c. Injury at Work? 1 ☐ Yes 2	:	ne 5 Res 28d. Describe		6 □Other (Spe y occurred	ocify)
Division	or Atten offer deat Director; in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, st				28f. Location City or To	(Street an wn, State	d Number or R	ural Roule Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2 Medical Exar	ysician: To the best of my niner: On the basis of exa- and manner stated.	knowledge, deat mination and/or in	vestigation	, in my opinion,	death occurr	and due to the ed at the time.	cause(s) , date and	and manner as I place, and due	s stated. e to the cause(s)
	To T To T EOS	×	29b. Signature and title of certifier	O			> 180(				te signed (Mont	th, Day, Year)
S/	1-6		30. Name and address of person who  DR VASANT DATTA  31. Date filed (Month) Day, "Year)	completed cause of death 340 MILL ST	REET, H	AGERS		ARYLAN	D 21740	) 3	801-739-	-7100
	Sta Registi		SED 0 1			Total !	,					

DHMH 17 Rev 1/2001

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				artment of Health and Mertificate of Death	ental Hygien	/ IIII h	28954
•	Physici /Medic		Decedent's Name (First, Middle, Last)     VIOLET VIRGINIA MOYER		2. Date of Death Month D	ay Year 2006	3. Time of Death 2:10 A
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
	Funeral	^	804 ORCHARD MANOR DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	WASHII 9. Birth	NGTON  place (State or Foreign intry)
	Director		212-24-3243 1□M 2및F 82 Yrs.	Months Days Hours Min.	APR. 10,		RYLAND
	/iand		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	e Man Ba-f sh	ctor	MARYLAND WASHINGTON	BOONSBORO			1⊠Yes 2□No
	with the	Directo	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	,
	death	Funeral	804 ORCHARD MANOR DRIVE  11. Marital Status  12. Was Decedent Ever in U.S. 13.	21713 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	U.S.A. 14. Race - Ameri	ican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mudical Exaculty continued at	by Fu	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes Give	1 ☐ Yes 2 ☑ No Specify:	rican, etc.)	Black, White	
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a	permit. Pages Department of important: If i any injury or o		21. Sign sture of the Prairie pare Lice see	22. Name and Address of Facility AST FUNERAL HOME	7606 Old N	Mational	Pike
m =	₹0.5 % a		23a. Part1. Enter the disease or complications that caused the death. Do not en		Boonsboro,	Marylan	d 21713 Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.		respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	RS DISONSE			years
	Examiner	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	outed Id ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events				
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68760	ate hy:	edicai	d				
Box (	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	,
P.O. B	ne deal the att	Physician/Me		Other (specify)	<del></del>	Month	Day Year
<u>.</u>	res that the de igned by the a be detached f	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	w requires been sign should be		DIABETES	·	1 ☐ Yes	2 <b>X</b> No 3□Pro	bably 4 □Unknown
ecc	ne iaw re s has be ge 2 sh	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	(7)		25. Was case referred to medical	26. Place of Death	performed?	death?	2□No
<u></u>	Attending Physician: Ir death. ector: After this certifics by the funeral director. I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ont 3 DOA Other: 4 Nursing Hon		6 ☐Other (Speci	fy)
0 00	ding Phys		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how inj	ury occurred	
/isic	or Atteno after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, si		8f. Location (Street a	ınd Number or Rur	al Route Number,
	rs after al Dire	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	re)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause( d at the time, date ar	s) and manner as s nd place, and due t	stated. to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certified	29c. License number	29d. D	ate signed (Month,	
				D32171		8/3:1	06
4	1-2-		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	100 St. 14 1 7	MD	21793
	Sta		31. Date filled (Month, Day, Year)  SEP 0 1 2006  32. Ragistrar's Signature	1	CONS VILLE	/ 0	2110
	Registr	ar	SEP 0 1 2006 Been B. D.	pere			

ician dical	1. Decedent's Na	me (First, Middle	e, Last)		Cer	tificate of	Death	2. Date of I		2006	28955 3. Time of Death
dicai	James	Edward M	forris, J	r.				Augus	t 25.		7:35 P.M.
niner			, give street and n			4b. City, Town,	or Location of D			County of Death	
		anor Nur	sing Hom	e		Wes	ternpor		A	11egany	
al	5. Social Security		6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of 8 (Month,	Birth Day, Year)	9. Birth	place (State or Foreign
or	217-18- Usual Residence		1 <u>14</u> 3 M 2	8.	5 Yrs.			09/20	/1920		ole, MD
	10a. State	10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
to	MD	Alleg	anv		Wester	nnort					1 ☐ Yes 2 💢 No
201049 To Be Completed by Funeral Director	10e. Street and N		,		WODECT	10f. Zip Code			10g. Citi	izen of Whal Cou	intry?
a o	25701 S	hady Lan	ne SW			21562			U	.S.A.	
Funeral Director	11. Marital Status		Amed		J.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No-	14. Race - Amer Black, White	
bv Ft		rried 2 Marri	ied 1X Yes	2 <b>□ №4 / 1</b>	943   ,	☐ Yes 2X No				Specify:	
ed b	3 MT AAIGGMAG	15. Decedent		Date3:/31/	-	ent's Usual Occu	nation		165 Ki	Wind of Business/li	nite
olet	(Sp	ecify only highes	st grade completed	·	(Give	kind of work done	during most of	working	100.10	ila di Dusiliessiii	loustry
Completed	6	condary (0-12)	Сонеде	(1-4or 5+)	Tre	e Trimme	r		Lan	dscaping	ŗ
Be	17. Father's Nam	e (First, Middle,	Last)				18. Mother's	Name (First, Mido	lle, Maiden	Sumame)	
0		Edward M	lorris				v	iola Ise	r		
	19a. Informant's	Name/Relations	hip <i>(Турө, Print)</i>		19b. Mailin	g Address (Stree	t and Number o	r Rural Route Nun	nber, City o	r Town, State, Zi	p Code)
			// Daught				eet, We	sternpor			
	20a. Method of D		3 □Removal from		cemetery, crem	sition (Name of natory or other pla	ice)	Date	20c. Lo	cation - City or T	own, State
		n 5 ☐ Other (S)		FO	tomac M Garde			30/2006		ser, WV	
	21. Signature of	Funeral Service I	Licensee	. 00				mith Fun	eral .	Home	
	230 Porti Ento	MEN	complications that	coursed the dea		Keyser,				T	Approximate
	shock, or h	eart failure. List	only one caus of	each line.	~ /					0 f.	Approximate Interval Between Onset and Death
n al	disease or condi resulting in deat	tion	a. All	nal	Saul	we	due	to.	Laa	Golec)	
			, cue i	On as a conse	queixe oi):	- Olive					5 Um
e e	Sequentially list if any, leading to	immediate	Due to	o (or as a conso	quence of)	nearly					fee
-=	anusa Catavilla	or injury		•		//					
E	cause. Enter Un Cause (Disease that initiated ever	nts	С								
Examiner	Esquentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	nts i) Last	c Due to	o (or as a conse	quence of):		· · · · · · · · · · · · · · · · · · ·				
ical	resulting in death	nts i) Last	c	o (or as a conse	quence of):	<i>()</i>					
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ical	resulting in death	ent pregnant 12 months? 2 \( \sum \) No	d	utcome of pregr birth 2 □ Fet gnant at time of	nancy al death 3	Ectopic pregnand Other (specify)	÷у		-		•
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edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deced in the past 1	ent pregnant 12 months? 2 □ No vn nificant condition  erred to medical No an 5 □ Pendin investig 6 □ Could r determ 1 □ Certifyin 2 □ Medicel	d	utcome of pregressions of pregressions of pregressions of pregressions of pregressions of pregressions of pregressions of pregressions of examinations of exam	sulting in the unsultin	Other (specify) _ derlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying graderlying cause graderlying graderlying cause graderlying cause graderlying graderlyi	26 Place of her:  4 Nursing at larger at large	24a. We are per per per per per per per per per p	d tobacco u  Yes 2  as an topsy formed? 2 [No y one) sidence 6 e how injun (Street and own, State, the cause(s) e, date and	Month  se contribute to  No 3 Pro  24b. Were aut prior to or death? 1 Yes  Contribute to  A Number or Run  and manner as a place, and due to	the cause of death?  bably 4 Unknown  opsy findings available ompletion of cause of  2 No  fy)  al Route Number,  stated.  o the cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

IIG LEWIS IVI		1- For State Registrar		i Marylanc			e of Deat	h		Re			2895
Physicia ical Exami													Time of Death 0958 hrs
icai Exaiiii	lilei	4a. Facility Name (if not			er)		4b. City.	own, or Location		September	4c. County		
		10022 Stedwick	Road Apar	tment 301			Monte	omery Villag	е		Montgor	nery	
Funeral Director		5. Social Security Numb 169–48–1631	1 X	7. A	49	ast birthda	Month Yrs.		$\overline{}$	8. Date of Birth	-1956	Foreign	y) PA
any		Usual Residence of Dec 10a. State 10b.	County		10c. City,	Town or	Location						d. Inside City Limits
and show nce.	ō	MD M	Montgome	ry	Ga	ithe	rsburg					1	X Yes 2 No
Maryla 28a-f d at o	Director	10e, Street and Number					10f. Zip	Code		10	g. Citizen of Wh	nat Country?	
h the 3a or		10022 Stedw						0877			U.S		
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland bearing register of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11, Marital Status  1 Never Married		12. Was Deceder Armed Forces 1 Yes		S. 1		nt of Hispanic Ori y Cuban, <b>M</b> exican				- American e, etc.	Indian, Black,
after o	by F		X Divorced	Yes, Give Year or Dates:				X No specify.			Specify:	White	
hours natur Cxam		15. Decedent's Educat						Occupation (Give king life. DO NOT			16b. Kind of Bu	siness/Indu	stry
in 72 han " tlical I	plet	Elementary/Secondar	y (0-12)	College (1-4 o	r 5+)	LPN	/Progra	m Coordi	nator		TheraC	om	
wild be filed within 7 Mental Hygiene marked other than c event, the Medica	Completed	17. Father's Name (First	, Middle, Last)	7							laiden Surname		
be filed ital Hy ked o	Be C	James T.	Martin					Dor	a E.	Knight			
ould b d Men s mar iic eve	To		formant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S									n, State, Zip	Code)
nd 2 sho alth and m 27 is aumati			, 11									17257	
permit Pages I an Department of Hea Important: If iter injury or other tra		20a. Method of Disposition 1 Burial 2 X C		Removal from S			isposition (Nar or other place)			Date	20c. Location -	City or Tow	n, State
Page nent c ant: or oth			Other Specify:			thsbu	rg Cremat		9-5-2	2006	Smithsbu	rg, MD	
Departr Import njury	,	21. Signature of Funera	Service License	ee	_	,,,		Address of Facilit	•	12525 1	)	M	
hysician		23a. Part I. Enter the dis	sease, or complic	cations that cause	ed the death.	Do not e		ris Funeral of dying, such as o					pproximate Interval
/Medical		failure. List only or			sive at	herns	clerotic	cardiovasc	ular d	i sease		E	Between Onset and Death
xaminer		Immediate Cause (Final or condition resulting in		ue to (or as a cor			21010110	CAT GIO VILO	JOILUI C			<del>- +</del>	
Service Service		Sequentially list condition	ons, b										
- Salit	iner	if any, leading to immed cause. Enter Underlyin	g Cause	ue to (or as a cor	nsequence o	f):							
i	Examiner	(Disease or injury that in events resulting in deat	IIIIaled -	ue to (or as a cor	nsequence o	f):							
ecuted and transit			d										
cate be exphysician	Medical	X UNPENDED		AMENDED i	tem#23a	,27,pe	erME,g859	,9/18/06 T	Т				
ficate be g physics the buri	****	IF FEMALE: 23b. Was decedent preg	nant in the	23c. If yes, outo	ome of preg	_	Fetal death	3 Ectopi	ic pregnanc	ער	23d. Date of Month	delivery Day	Year
n certifi ending use as	Physician	past 12 months?			at time of de	2 Leath 5	Other (Spe		ic pregnan	-y	Wiorian	Day	Teal
e death c the atten ed for us	hysi	1 Yes 2 No 9		9 Unknown									
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	   by	Part II. Other significar	nt conditions	contributing to de	ath but not re	esulting ir	the underlying	cause given in P	art I.			_	cause of death?  4  V Unknown
quires en sign				-						24a. Was a			sy findings available
The law requir ficate has been s , page 2 should l	Completed									autops	sy p		oletion of cause of
The L	ह		1							1 Yes 2		✓ Yes	2 No
ysician: The nis certificate director, page	Be (	25. Was case referred t examiner?	_	spital:		1		26.Place of Death	<del>-</del>			77	
Physician: er this certi ral director	욘	1 Yes 2	No	28a Date of Ir	tient 2			28c. Injury at Worl	Nursing		Residence 6 ow injury occurr		ane
ding Ph h. After t funeral	on:	1 X Natural 5	Pending	(Month, Day	y,Year)	200. 111	ie or injury	1 Yes 2	. 1	od. Describe II	ow injury occurr	eu	
or Attend after death Director: I in by the	cati	2 Accident	Investigation	28e Place of	Injury - At h	ome farm	street factor	, office building, e		8f Location (S	treet and Numb	er or Rural F	Route Number, City
Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	3 Suicide 6	Could not be determined	e (Specify)	injury - Acti	omo, idiri	i, di dai, idalai	, omeo banang, o		or Town, St		or or rearen	todio Hambor, ony
Hospital 24 hours a Funeral tely filled		29a. Certifier	tifving Physicia		mv knowled	ge, death	occurred at the	time, date and pl	lace, and d	ue to the cause	e(s) and manner	as started	
To the Ho within 24 P To the Fun completely	Medical	(Check only one) 2 Med	lical Examiner:	On the basis of e	xamination a	nd/or inve	estigation, in m	opinion, death o	ccurred at	he time, date a	and place, and o	lue to the ca	use(s)
₹ .½ °C .	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed										ed (Month,	Day, Year)
		Santit 9	withe.11	MO				O.C.M.E.			September	2, 2006	
		30. Name and address						-	-		-	· · · · · · · · · · · · · · · · · · ·	
		Pamela Southa	all, MD As	sistant Medic	al Exami	ner 1	11 Penn S	reet, Baltimoi	re, MD 2	1201	<u></u>		
	tate			500	trąr's Signati	ure	-						
Regis	strai	81	FP 1 9 2	006	and	Bath.	A	6					

		1- For State Registrar  1. Decedent's Name (First, Middle, Last,		Ce	ertificate of	Death	2. Date of Dea	th	3. Time of Death
Physici /Medic	al	Eugene Pat		rthy	4b. City, Town, o	r Location of Dog		ber 2, 20	006 5:10 AM M
Examin	er	7043 Basswood	l Drive		Freder	ick		D J.	rick
Funeral Director		5. Social Security Number  6. Security Number  7. Security Number  1. Security Number	7. Age	(In yrs. last birthda 81 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1924 P	Birthplace (State or Foreigr Country) ennsylvania
Maryland e-f ehow	ctor	10a. State 10b. County  Maryland Frederic		10c. City, Town or Frederi					10d. Inside City Limits 1 ☐ Yes 2 No
h with the 23a or 28	Funeral Director	10e. Street and Number 7043 Basswood Ro	oad		10f. Zip Code 21703		1	0g. Citizen of Wha U.S.A.	t Country?
ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It is the firm 27 is marked other than "natural", or items 23a or 28e-f ehow or other traumatic event, the Madical Examinar mount be mailfied at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 XiYes 2 ☐ No If Yes, Give 10 Year or Dates.		B. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ▼ No	ispanic Origin? ( nn, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc. White
within 72 ho ane. than "natur in Wedical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occup re kind of work done of DO NOT use retired	during most of w	rorking	16b. Kind of Busine	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Market aumatic event.	To Be Co	17. Father's Name (First, Middle, Last) Aloysius 1	4 McCarthy		aining Sp	18. Mother's Na	ı ame <i>(First, Middle, 1</i> zabeth Coy	Maiden Sumame)	actons
ss 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Mrs. Marion M. McC		fe 7043	iling Address (Street is Basswood	Road,	Rural Route Number Frederick	City or Town, Star , MD 2170	te. Zip Code) 13
Pa pi di Pa		20a. Method of Disposition t ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of Disp cemetery, cr Smithsbur	position (Name of ematory or other place g Crematory	Sept.	. 3, 2006	20c. Location - City Smithsbur	
permit. Pag Department Importent: i eny injury o once.		21. Signature of Funeral Service Licers			22. Name and Addres Keeney and 06 East Cl				21.701
Physician /Medical Examiner	er	23a. Pant1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	A	g, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
cate be executed physicien and the burial-transit	dical Examin	Sequentially list conditions, if any, leading to indirect cause. Either Underfying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
I ne law requires that the death centil ste has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	☐Ectopic pregnancy			23d. Date of Month	delivery Day Year
w requires that been signed I should be det	2	Part II. Other significant conditions cor	ntributing to death but	not resulting in the		en in Part I.			e to the cause of death?  Probably 4 Unknow
	Completed	Hypertens	ion!				24a. Was all autops perform	y prior ned? death	autopsy findings available to completion of cause of 1? res 2 \(\text{\text{\text{No}}}\)
ystc is ca direc	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 ER/Outpatie	ent 3 DOA Othe	ne:	Home 5 Reside		Snocify)
a After	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day)	28b. Time (ear) Injury	of 28c. Injury Work			w injury occurred	peony
크를		4 Homicide determined	28e. Place of Injury building, etc.	(Specify)			City or Town	, State)	Rural Route Number,
ne Hospital	edical	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	sicien: To the best of ner: On the basis of each and manner state	xamination and/or i	ath occurred at the tim investigation, in my op	e, date and place pinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner ate and place, and o	r as stated. due to the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	len'ch	9d. Date signed (M	onth, Day, Year)

			1 - For State Registrar	State of Maryland / [	Depa Cert	rtment of H tificate of L	ealth and Death		Reg. No	2006			
F	Physici /Medic			omer				2. Date of De Month August	Da		3. Time of Death  12:30 A		
	Examir Funeral		4a. Facility Name (If not institution, give s  7114 Edgemont Road  5. Social Security Number 6. Sex	7. Age (In yrs. last bir		4b. City, Town, or Fre If Under 1 Year Months Days	ederick If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ly, Year	Frederic 9. Birth	h k nplace (State or Foreign untry)		
	Director		215-26-1195  Usual Residence of Decedent  10a. State 10b. County	10c. City, Town		ation		Dec. 30	J, 15	919   Mar	yland  10d. Inside City Limits		
	with the Mar a or 28a-1 et be notified	Director	Maryland Frederic	k Fred	eric	10f. Zip Code			-	itizen of What Co	•		
036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-1 ehow ta Madical Exaint et musi be notified at	by Funeral	7114 Edgemont Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:		21702 Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)		Inited S  14. Race - Ame Black, White Specify: Wh	ncan Indian, a, etc.		
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 5	5 Homemaker									
land	should be filed nd Mental Hygir marked other Imatic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Luther James Staub	uther James Staub Sarah Baugher									
Mary	ges 1 and 2 should it of Health and Men if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Typ Margaret Rice / Dat		nr, City or Town, State, Zip Code) MD 21702								
more,	Pages 1 a nent of Hei int: if item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20c. Location - City or Town, State								
Balti	permit. Page Department Important; if any injury or once.		21. Signature The rail Service License	kkot Cod rick, MD	y P.A.								
,	Physician /Medical Examiner		23a. Part1. Enter the disease for complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Congestive Hear	t Fa	ilure		c or respiratory a	rrest,		Approximate Interval Between Onset and Death  Weeks		
58/60,	ficate be executed physicien and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Acute Myocardia  Due to (or as a consequence  Atherosclerotic  Due to (or as a consequence	<sup>of):</sup> Car			ase			2 weeks years		
P.O. Box 6	The law requires that the death certific ite has been signed by the ettending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25k No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year		
	w requires that been signed b should be dete	by	Part II. Other significant conditions con Diabetes Mellitus				n in Part I.	101	Yes 2	<b>⊠</b> No 3 □ Pro	the cause of death?		
Vital Hecords,		e Completed	25. Was case referred to medical				26 Place of Dea		osy ormed? 2\overline{\ove	prior to death?	topsy findings available completion of cause of		
<u> </u>	yeici is cer direci	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou	itpatient	3□ DOA Othe				6 ☐ Other (Spec	ufv)		
ion of	Attending Phar death.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	ry occurred	,,								
DIVISION	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerai Director: After this certifical completely filled in by the funeral director.	Certification:											
	the Hospi nin 24 hour the Funer npletely fill	edicai	(Check only 2 Medical Examir one)	sicien: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death o	estigation, in my op	inion, death occu	irred at the time,	date an	d place, and due	to the cause(s)		
	or To	×	29b. Signature and title of certifier			D 26.				gust 28,	*		
	1		30. Name and address of passon who co Allen J. Gilson, M			·	rick MD	21702					
	Sta		31 Date filed (Month Day Year)	32. Resistrar's Signature			LICK, III	21102					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Thomas 8:45P M William Ness August 26, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □XM 2 □ F 64 Yrs. Director 165-36-4123 Jan.4, 1942 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, "is Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13106 Manor Drive 21771 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Itema 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Emmanuel Ness Martha Mary Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Jane M. Ness - Wife 13106 Manor Drive, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if its any injury or otl 1 Burial 2 Cremation 3 Removal from State Sesquehanna Mem. Gdn. 8/30/06 York, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signifure of Funeral Service Licensee Molesworth Williams P.A., Funeral Home tovere 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATIONS FMUNE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FALLURE CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed CARDIO that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. LYMPHANGIECTASII 2 □No 3 □ Probably 4 □Unknown PHEDEMA LEGS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2010 : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35965 QUGUST 27,2006 30. Name and address of person who completed cause of death (Nam 23a) (Type, Print) 5 HARPING -602 CENTER ST. #209 MD. 32. sistrar's Signature 31. Date filed (Month, Day, Year) AUG 2 9 2006 State Registrar

•	7		1 - For State Registrar	State of	Maryland.		artment of F		nd Mental Hy	giene Reg. No. 2	በበፍ	28960			
			Decedent's Name (First, Middle	a, Last)					2. Date of De	ath		3. Time of Death			
	Physici /Medi		Rochelle Andre	a Oliver					Month 08	27	Year 2006	4:55 A M			
	Examir		4a. Facility Name (If not institution		ber)		4b. City, Town, o	r Location of	Death	4c. Cour	ty of Death				
			Washington Adv	entist Hos	pital		Takoma I	Park		Mont	gomery	7			
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 💢 F	. Age (In yrs. last		If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th i <i>y, Year)</i>	9. Birthpla Count	ace (State or Foreign			
	Director		577-08-7280 Usual Residence of Decedent		37	Yrs.			09-0	4-68	Dist.	of Colum.			
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation				10	d. Inside City Limits			
	Many First	ğ	DC		Wa	shing	gton					M∑Yes 2 No			
	h the	rec	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Count	ry?			
	th wit	ai	1315 Columbia E	Road NW, A	partment	102	200	09		USA					
	r dea	Funeral Director	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S.	13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	)- 14. R	ace - America ack, White, e				
36	or li	by Fu	1 Never Married 2 Marri	ied 1 ☐ Yes 2 If Yes, Give	<b>(</b> □ No		1 ☐ Yes 2 🏋 No	Specify:			ity: Blac				
Ö	tural	b p	3 Widowed 4 Divorced	Year or Dat		Sa Dagg	toot's Havel Ossue	****							
Ϋ́ Ω	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show fra Medical Examinar must be notified at	Completed	(Specify only highes	st grade completed)		(Give	tent's Usual Occup kind of work done o DO NOT use retired	during most o	of working	160, Kind of	Business/Indi	ustry			
212	l with	E O	Elementary/Secondary (0-12) 12th	College (1-4	for 5+)		eptionis	,		Priva	te				
פ	othe vent,	BeC	17. Father's Name (First, Middle,	Last)					s Name (First, Middle,						
Maryland 21215-0036	wild b Menta wrked ritice	To	Walter Oliver					Marga	ret Matthe	ews					
au	2 sho and l	i h	19a. Informant's Name/Relationsh	nip (Type, Print)	1	19b. Mailir	g Address (Street	and Number	or Rural Route Numbe	er, City or Tow	n, State, Zip (	Code)			
	end m 27	1	Walter Oliver	/ Father				pitol	St NE, Was						
altimore,	T Ite	l ï	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 □Removal from St	ann.	of Dispo etery, cren	sition (Name of natory or other plac	(e)	Date	20c. Location	- City or Tow	n, State			
<u>=</u>	Pa tmen tant:		4 □Donation 5 □ Other (Sp	pecify)			ln Cemet			Brentw					
Ba	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, II a Medical Examinar must be notified at once.		21. Signature of Funeral Service	Marsh	a 80	22	. Name and Addres		Marshall's 17 9th St						
			23a. Part Enter the disease, or shook, or heart failure. List	complications that cau	used the death. D	Do not ent	er the mode of dyin					Approximate Interval Between			
y.	Physician		Immediate Cause (Final disease or condition	Seps								Onset and Death			
÷.	/Medical		resulting in death)	a	as a consequen	ce of):									
	Examiner		Sequentially list conditions,		Human Immunodeficiency Virus										
	p ti	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):											
	and I-tran	Examin	that initiated events resulting in death) Last	c. AIDS											
8760,	icate be executed physicien and s the burial-transit	aiE		240 (0)	as a consequent	Ce Oi).					1				
687	phys s the	dicai		d											
Вох	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		me of pregnancy					23d D	ate of deliven	4			
ň	death e atte d for	icia	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	4□Pregnar	h 2 ☐ Fetal dea nt at time of death		Ectopic pregnancy Other (specify)					ay Year			
O.	that the de led by the a detached t	hys	9 □ Unknown	9□ Unknow	'n										
	es tha igned be del	by P	Part II. Other significant condition	ns contributing to dea	th but not resulting	g in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use co	ntribute to the	cause of death?			
ğ	w require been sig should b	ed							_ 101	res 2□No	3 🗌 Probal	bly 4 <u>M</u> Unknown			
Records,	e law re has be ge 2 shi	pie							24a. Was	an 24b	. Were autops	sy findings available			
ř		Completed							perfo	rmed? 2 X No	death?				
Vital	ysician: Th	Be (	25. Was case referred to medical examiner?			_		26. Place of	Death Check only o						
6	Physic this c	မှ	1 ☐ Yes 2 💢 No	Hospital:		Outpatien	-	4   Nursi	ing Home 5 Resid						
ב	ing	io	27. Manner of Death 1 XNatural 5 ☐ Pending	9	Injury 28t Day Year)	o. Time of Injury	28c. Injury Work	ς?	28d. Describe h	now injury occu	rred				
<u>s</u>	ktendi death. ctor: A y the fu	icat	2 Accident investig 3 Suicide 6 Could n	not be	Hairray At hama	fa1		Yes 2 □ No		24					
Division	E Piete	Certification:	4 Homicide determi	ned 28e. Place of building	Injury - At home, , etc. (Specify)	, tarm, stre	et, factory, office		28f. Location (5 City or Tox	otreet and Num vn, State)	iber or Rural i	Route Number,			
	To the Hospital within 24 hours e To the Funeral Completely filled	edical C	(Check only 2 Medical E	g Physician: To the be Examiner: On the bas	est of my knowled	dge, death	occurred at the timestigation, in my or	ne, date and p	place, and due to the	cause(s) and n	nanner as stat	led.			
	To the P	Medi	one)  29b. Signature and title of certilier	and manne	r stated.		29c. License								
	1 1 8	-	255. Signature and title of central						1	29d. Date sign					
1	(3)		30. Name and address of person v	the nemalated	of don't /l CC	a) (T	DO 6	0100		MUGUS	T 27	,2006			
ک.	Je		DR. TAHMINA	AHMEL	Or Death (Item 23a	a) (1ype, 1	N/IVERCI	TUR.	o LVD. SIL	100 51	00 1010	20903 Md			
2	Sta	te	31. Date filed (Month, Day, Year)	<b>∅</b> 32. Reg	istrar's Signature		1010 CR31	17 106	UVV. DIII	LEK OF	KING	110.			
	Registr	ar	SEP 0 1 2086	Blow &	Lange	E .									

Ub-Ub486 Please Type or Print in Black Indelible Ink Boyce Price State of Maryland / Department of Health and Mental Hygiene 2006 2896 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day August 29, 2006 Medical Examiner 1922 hrs BOYCE PRICE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Hospital Center Ft. Washington Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min Director 578 64 3173 12/29/1948 WASHINGTON, DO XX M 2 F 57 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location any 10d. Inside City Limits 28a-f show 1 X Yes 2 No PRINCE GEORGES FORT WASHINGTON netified at once. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2302 PIONEER COURT 20744 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 4 X Divorced If Yes, Give Year 1967-70 Widowed permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. Yes 2 X No specify. Specify: BLACK ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 1 YR. SECURITY LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) BOYSIE WILLIAMS ANNIE B. PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIOLET SILESHI / SISTER 1016 OSAGE ST. SILVER SPRING, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) METROPOLITAN CREMATOR \$\fomale 09/03/06 Donation 5 ALEXANDRIA, VA Other Specify agnature of Funeral Service Licensee 22 MARSHADES SFORWNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 rt I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ure. List only one cause on each line 8etween Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 2 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: ✓ Natural 5 Pending 1 Yes 2 No the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) mo O.C.M.E. August 30, 2006 J 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 SEP 0 1 2006 32. Registrar's Signature State Registrar

			For State	St	ate of M	laryland /		rtment of			Mental I	Hygien Reg. N	00	0.6	2006
(A)E	2/		Registrar  1. Decedent's Name (First, Midd	dle. Last)			001	incare o	1 500	.,,	2. Date of	Death		Ub	3. Time of Death
	Physici		Helen C. Pla		9						Aug.	24	-	Year 106	3:00a M
	/Medic Examin		4a. Facility Name (If not institution			)		4b. City, Town	, or Locati	on of Death				of Death	1 0 0 0 0 0
	18. E.	æ.	8314 Sycamore	Road					Mil	lersv	ille		Anr	ne Arı	undel
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. last b		If Under 1 Yes		der 24 Hrs. rs Min.	8. Date of	, Day, Year	)	9. Birthp Coun	lace (State or Foreig
de l	Director		218-14-1481	I L M	ZUALT	83	Yrs.				May 2	20, 19	923		WV
	and	1	Usual Residence of Decedent  10a. State 10b. Count	у		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number					10f. Zip Code		SVIII		10g. C	itizen of	What Coun	ntry?
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	ema ema	Funerai	11. Marital Status		as Decedent		13. V	Vas Decedent o Yes, specify C	f Hispanic	Origin? (Sp	ecify Yes o	r No-		e - Americ	
2	or It	by Fu	1 Never Married 2 Ma	. If	Yes 215 Yes Give	No		☐ Yes 2XIN						. Whi	
Maryland 21212-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itema 23a or 28a-f show aumatic event, the Medical Exacular must be notified at	d be	3X Widowed 4 □ Divorce	nt's Education	ear or Dates:	1 16	a Deced	ent's Usual Occ	cupation			16h	Kind of B	usiness/Inc	duetor
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g	il Hygi other	Bec	17. Father's Name (First, Middle						18. M	other's Nam	e (First, Mic	ddle, Maide	n Suman	ne)	
<u>a</u>	utd be Mental irked c	ToE	Evangelos Car	diges					An	igela '	Vavilo	ousaki	.s		
a D	2 sho and l		19a. Informant's Name/Relation					g Address (Stre							Code)
	and lealth m 27 her tr	1	Gale P. deBor	ja/Dau	ghter			Sycamo	re Ro				•		
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked eny injury or other traumatic es 80ce.		20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation	n 3 □Remo	val from State	cemet	ery, crem	sition (Name of natory or other p			28,			City or To	
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	STEWN		23a. Part1. Enter the disease,	or complicatio	ns that cause	ed the death. Do							l Pal	K, MIL	Approximate
			shock, or heart failure. List Immediate Cause (Final	st only one ca	use on each I	line.	71	,							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Due to (or a	s a consequence	e of):	~							
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J "-	Due to (or as	s a consequenc	e of):								
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	) c											
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9 xo	To the Hospital or Attending Physician: The law requires that the death certific; within 24 hours after death. To the Funeret Director: After this certificate has been signed by the eltending pl completely filled in by the funeral director, page 2 should be detached for use as t	/Me	IF FEMALE:	23c If	ves outcome	e of pregnancy							024 Da	to of dollar	
å	etten for us	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes  2 ☑ No	1	Live birth	2 ☐ Fetal dea at time of death		Ectopic pregnal Other (specify)						te of delive onth	Day Year
o.	the d	ysic	1 □ Yes 2V No 9 □ Unknown		Unknown	at thine of doubt	3_	Other (specify)							
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æ	The la	Completed							•		10 Y	utopsy enformed? es 2 V/N		prior to coi death? 1 □ Yes	
Division of Vital Records,	ian: rtifice ctor. p	Be C	25. Was case referred to medic examiner?	al					26. P	lace of Deat					
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Sio	death death ctor: /	cat	2 Accident Inves	tigation d not be					☐ Yes 2	2 🗆 No	Opt Least	(0)			/O N - 1
$\leq$	or At after c Direc in by	Certification;	4 Homicide deter	mined 28		njury - At home, etc. <i>(Specify)</i>	tarm, stre	eet, factory, office	СӨ		City of	Town, Sta	ina Numi te)	oer or Hura	il Route Number,
	Hospital or At 24 hours after of Funerat Direct stely filled in by		29a, Certifier Certify	ring Physicia	n: To the bes	t of my knowled	ne death	occurred at the	time date	e and place	and due to	the cause/	s) and m	anner as s	tated
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funere! Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medica	al Examiner:	On the basis and manner s	of examination a	and/or inv	estigation, in m	y opinion,	death occur	red at the ti	me, date ar	nd place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and Ne of certif	ier				29c. Lice	ense numb	per		29d. D	ate signe	d (Month,	Day, Year)
			► XHXT	VW)	*				4)0	127	-		8.	74-	06
			30 Name and address of perso	n who comple	tedicause of	death (Item 23a	ј (Туре,	Sint) LI ~	11	1.1	01	Des	Λ	.11	107/120
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		501													

State of Maryland / Department of Health and Mental Hygiene 2006 28963 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death AUGUST26 **Physician** 2006 PHILLIPS DONABEL 11.45a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 15, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs 81 Director 118-16-6875 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ? Is marked other than "naturel", or Iteme 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 ☐ No Directo Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 5800 Genesis Lane 21703 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eldridge Meechum Lucille Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Phillips / Stepson 6916 Palace Court, Frederick, Maryland 21703 item 27 other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 9/6/06 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign dure of Fune al Service Lice ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 atione that caused the e cause on each line Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest orclewhe Cardwaren Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificete 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2. ER/Outpatient 3 DOA Sig After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29c. License number completed cause of death (Item 23a) (Type, Print) AUG 2 9 State Registrar

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			for State Registrar		, mary tarr	•	rtificate of		ina montan	Reg. No	200	6 28961
	Dhariai		1. Decedent's Name (First, Midd	le, Last)					2. Date of	Dogth		3. Time of Death
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	Funeral Director		5. Social Security Number 348-03-9415	6. Sex 1 □XM 2 □ F	7. Age (In yrs 88	Yrs.	Months Days		Min. (Month,	Birth Day, Year	9. Bird	thplace (State or Foreign ountry)
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	nylan show	-	10a. State 10b. County	1	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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(0	r Ren d	E	1 ☐ Never Married 2 🔯 Mar	Armed For	ces?	.5. ,0.	If Yes, specify Cu	ban, Mexican,	gin? (Specify Yes or , Puerto Rican, etc.)	140-	Black, Whit	
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21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f show than Marical Exercitor mast be notified at	Completed		nt's Education est grade completed)		16a. Dece	dent's Usual Occi	upation e during most	of working	16b. K	(ind of Business	/Industry
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au	d be sental	To Be		ker				Haz			, Jumanie,	
Maryland	should Maria	-	19a. Informant's Name/Relation:			19b. Maili	ng Address (Stree		r or Rural Route Nu		or Town, State, 2	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment if Item 27 is marked other than "natural", or Items 23a or 28a-f show enyoriant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injusting other treumatic event, the Madical Examiner man be notified at once.		Jane H. Parker	/ Wife		2509	Amherst	Road,	Hyattsvi	11e,	MD 2078	3
Baltimore,	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Romoval from 5		lace of Dispo	sition (Name of matory or other pl		Date	-	ocation - City or	
Ĕ	Pages ment of I		4 Donation 5 Other (	Specify)	1	ropoli	tan Crema	atory Au	igust 27 2006	Alexa	andria.	VA
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ı			23a. Part . Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	ach line.	n. Do not en	er the mode of dy	ring, such as o	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
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Box	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	incy					23d. Date of del	livon
ğ	death a atter d for u	iciar	in the past 12 months?	1☐Live bi	rth 2 ☐ Fetal ant at time of de	Ideath 3[	Ectopic pregnant Other (specify)	cy			Month	Day Year
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ord	w require been signature					<del></del>			1	□Yes 2	□No 3□Pr	robably 4 Onknown
Records,	4 S CA	Completed							24a. W	topsy	prior to	utopsy findings available completion of cause of
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0	ding Physician: The In. After this certificete hat funeral director, page	<b>-</b>	27. Manner eath	28a. Date o	of Injury	ER/Outpatier 28b. Time o	" OD DOX	4 L Nui	sing Home 5 R			cify)
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Division of	or Atten efter deatl Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 286. Place	of Injury - At ho	ome, farm, sti	eet, factory, office	9	28f. Locatio City or	n (Street ar Town, State	nd Number or Ru	ural Route Number,
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١	041		30. Name an addres of person	who completed caus	e of death (Item	1 23a) (Type,		1-/			J - W	- 2006
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	Physici		1. Decedent's Name (First, Middle, Rosemarie Rice	Last)							2. Date of De Month August	ath Da	<b>~ · · ·</b>	<b>ур</b> Үөаг 006	3. Time of 5:58	P M
	/Medio Examin		4a. Fecility Name (If not institution,	give street and n	ımber)		4b. City, To	wn, or	Location o	f Death	August		. County o		3:30	P
			Anne Arundel Med	dical Ce	nter		Annap	oli	s			Ar	nne A	rund	e1	
	Funeral Director		5. Social Security Number 045-28-9837	6.Sex 1□M 2፟M F	7. Age	(In yrs. last birthday Yrs.	Months [	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da March	v Yearl	1937	9. Birthp Coun	ace (State of try) nection	r Foreign
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	th wit	ai D	2816 Mockingbir	d Court			2140	1				Unit	ted S	tate	S	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or items 23s or 28s-f show event, I'm Medical Examination to collified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was De	edent Evorces?	er in U.S. 13	Was Deceder If Yes, specify	nt of His Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	-	14. Race Black	- Americ , White,		
Maryland 21215-0036	ours at	by	3 Widowed 4 Divorced	If Yes, G Year or	IVA		1 ☐ Yes 20	XXo	Specify:				Specify:	Wh	ite	
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	Ith 271		19a. Informant's Name/Relationshi Vincent Gerard (		S+ /	Husband					And And					
Baltimore,	es 1 and of Health fitem 27		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation			20b. Place of Disp	osition (Name ematory or other	of			ate All		ocation - C		21401 wn, State	
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Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Li	Don		11	47 Duke	of	Glou	cest		Ann	: Fundapol	eral	Home, MD 214	Inc.
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ecords,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	s contributing to	death but	not resulting in the	underlying cau	se give	n in Part I.		23e. Did to		./		e cause of d ably 4 □ U	
eco	law re nas ber a 2 sho	Completed						<u>.</u>			24a. Was	sv /	24b. W	ere autop	sy findings a	available ause of
a E			20.11		-1						perfor	rmed! 2☑ No	de	ath?	2□ No	
VItal	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes / 2 ☐ No	Hospital:	Inpatient	2 ER/Outpatie	ent 3 DOA	Othe	,-		<i>(Check</i> on <i>ly o</i> ne 5 ☐ Resid			/Canada		
Division of	ng Phy fter thi	on: T	27. Manner of Death	28a. Date		28b. Time		lnjury Work	at		28d. Describe h				) 	
<u>S</u>	ttendi death. tor: A the fu	icati	2 Accident investiga 3 Suicide 6 Could no	ation	( ) - :		М		es 2□N		201.1					
2	tal or Attending Ples after death.  al Director: After the din by the funeral	Certification:	4 Homicide determin	build	e or injury ling, etc.	/ - At home, farm, si (Specify)	treet, factory, o	ffice		2	28f. Location (S City or Tow	otreet an vn, State	a Number )	or Hural	Route Numi	oer,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the i	e best of pasis of e oner state	my knowledge, dea xamination and/or i d.	th occurred at nivestigation, in	my op	e, date and inion, deatl	d place, a h occurre	and due to the ded at the time, d	cause(s)	and manr place, an	ner as sta d due to	ited. the cause(s)	)
	To t To t	Σ	29b. Signature and little of certifier	meth	m		29c. L	) }	number 445			29d. Dat	te signed (	Month, I	ay, Year)	
	15		30. Name and address of person w	ho completed cau	se of dea	th (Item 23d) (Type	, Print) D	4	Ar	) Nt.	nel.	n	0			
	Sta		31. Date filed (Month, Day, Year)		Registrar	s Signature	-	1)		1	120112)	. /				
	Registr	ar	AUG 2 5	ZUUb	Salvan.		MARIE OF THE PARTY									

		-	For State Registrar	State of Maryland / D	epartment of Health Certificate of Deatl	and Mental Hygien	°2006 28966			
	٨		Decedent's Name (First, Middle, Las			2. Date of Death	3. Time of Death			
jet.	Physicia /Medic		James Wi	Iliam Roten		Jugh st 2	6 2006 23 55 M			
	Examin		4a. Facility Name (If not institution, give	and the second second	of Death 4	c. County of Death				
			2475 Liberty 5. Social Security Number 6.86		er 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign				
	Funeral Director			Mu alle	nday) If Under 1 Year If Under	Min. (Month, Day, Year	1915 Virginia			
			Usual Residence of Decedent			1.01.125	J			
	nrylan show	_	10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	8a-1	Director	MO Ceci	Col	10f. Zip Code	100.0	Citizen of What Country?			
	with t		2475 Liberty	Grove Road	21917	10g. 0	USA			
	death me 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic C	Origin? (Specify Yes or No-	14. Race - American Indian,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	Ď.	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specif		Specify: White			
5 0	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. I	Decedent's Usual Occupation (Give kind of work done during mo	ost of working	Kind of Business/Industry			
7	within ne.	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	Iron Work	ەن قىر	Iran			
D	filed y Hygie other t	ပ္သ	17. Father's Name (First, Middle, Last)			her's Name (First, Middle, Maide				
aŭ	id be ental kad o	To Be	Edward R	eten		Lula Mae	Enscore			
ary	and M • mar	-	19a. Informant's Name/Relationship (7	ype, Print) 19b.	Mailing Address (Street and Num	ber or Rural Route Number, City				
Σ	and 2 ealth n 27 I		Ann Riley/	Daughter 2	The second secon		olora, MD 21917			
altimore,	ges 1 t of Hi if iter or oth		20a. Method of Disposition  1 ■ Burial 2 ■ Cremation 3 ■	Removal from State cemeters	Disposition (Name of v, crematory or other place)	Aug. 29, 2006 ,	Location - City or Town, State			
ij	t. Par rtmen rtant: njury		4 Donation 5 Other (Specify	Verterry	22. Name and Address of Fac	Church Cem. F	Rising Sun, MD			
Ba	Depa Impo any is		21. Signature of Femeral Service Licen	CHAI	86 Pine S	treet Oxfe				
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do none cause on each line.	ot enter the mode of dying, such a	as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		years					
	Examiner									
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of	of):					
	cuted nd ransit	Examin	that initiated events	c. Due to (or as a consequence of						
Š,	cate be execul physicien and the burial-trai	Ä	resulting in death) Last							
8760,	icate be executed physicien and s the burial-transit	dicai		d						
9 X C	death certifi e attending ed for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy		23d. Date of delivery			
.O. Box	that the death certificed by the attending properties as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Month Day Year				
<u> </u>	iaw requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Pal	rt I. 23e. Did tobacco	o use contribute to the cause of death?			
Vital Records,	tuires n sign	d by				1 ☐ Yes	2 No 3 Probably 4 MUnknown			
S	aw requir is been si 2 should I	Completed				24a. Was an	24b. Were autopsy findings available prior to completion of cause of			
æ	0 - 0	шо			autopsy performed?	? death?				
ital	ysician: Th is certificete director, pag	BeC	25. Was case referred to medical examiner?	ace of Death (Check only one)						
of <	Physician: this certific ral director,	2	1 ☐ Yes 2 KNo	Hospital: 1 Inpatient 2 ER/Ou		Nursing Home 5 X Residence 28d. Describe how in				
onc.	ding F	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work?  M 1 ☐ Yes 2		jury occurred			
Division	ai or Attending etter death. i Director: After d in by the fune	fica	3 Suicide 6 Could not b	28e. Place of Injury - At home, fa.			and Number or Rural Route Number,			
á	rs efte al Dire	Certification:	4 Homicide	building, etc. (Specify)						
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	o, death occurred at the time, date d/or investigation, in my opinion, d	and place, and due to the cause feath occurred at the time, date a	(s) and manner as stated.  and place, and due to the cause(s)			
		ž	29b. Signature and title of certifier		29c. License numbe	211/	Date signed (Month, Day, Year)			
•			1 H tarker	, MD	V 15	>14 A	ugus/ 28, 2006			
	4		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)  Hospice, E	Ikton MD				
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	10)40	.,				
	Regist		AUG 2 9 2006	Steen It B	and a					

		1 - For Amend Item Registrar	F	DI.,6000,45	rtificate of	Death	Re	g. No. 200	6 2896			
Physicia	10	Decedent's Name (First, Middle,	Last)				2. Date of Death Month	h Day Year	3. Time of Death			
/Medic		John Tyler Rigb					August	25, 2006	11:45P			
Examine	er	4a. Facility Name (If not institution, g	give street and number	er)		Location of Death		4c. County of De				
		Union Hospital		A	Elkt	ON If Under 24 Hrs.	10.00	Ceci				
uneral irector		212-88-5934	1. Sex 1. 1 M 2 □ F	Age (In yrs. last birthda)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 25,	1970 De	inthplace (State or Forei Country) Laware			
*	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. fnside City Lim			
oh B	٥								1 □ Yes 2 1			
28e-	ect	Maryland Ced	cil	Elkt			10	ng. Citizen of What C	Country?			
T De	<u></u>	167 Little Elk (	Chach Dad	,	10f. Zip Code	1921	''	USA				
me 20	era	11. Marital Status	12. Was Decede		. Was Decedent of H ff Yes, specify Cuba		ecify Yes or No-	14. Race - An	perican Indian,			
If item 27 ie marked other than "natural", or itame 23a or 28e-1 show or other treumetic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force  1 ☐ Yes 2  If Yes, Give  Year or Date	X) No	ff Yes, specify Cuba 1 ☐ Yes 2 💢 No	Specify:	Rican, etc.)	Specify:				
al E	ed	15. Decedent's		16a, Dec	edent's Usual Occup	ation		   16b. Kind of Busines	White			
n n Medit	plet	(Specify only highest	grade completed)	(Giv	e kind of work done o DO NOT use retired	during most of work d)	ring					
atra a	Eo	Elementary/Secondary (0-12)	College (1-4d		. Equipmen	t Operati	or (	Constructi	ion			
othe /ent,	BeC	17. Father's Name (First, Middle, La	ist)				e (First, Middle, N					
le marked other than " eumetic event, Ine Mac	To B	William N. Rigby		405.44	U- 144 (O		1 L. Doba		T 0 11			
7 le n treun	- 1	19a. Informant's Name/Relationship			ling Address (Street: Little El							
ther		William N. Rigby 20a. Method of Disposition	gracie					20c. Location - City of				
Importent: If Item 27 any injury or other tre		1 ☐ Burial 2 [X Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe			position (Name of sematory or other place that Funeral Puneral		8-2006		, Maryland			
Importent: If any injury or one:		21. Signature of Funeral Service	nsee	Į.	22. Name and Address R. T. Foar 11 S. Que	ss of Facility d Funera						
		23a Part 1. Enter the disease, or co	omplications that caus	sed the death. Do not e	nter the mode of dvin	en St., I	or respiratory arre	<i>LN</i> . MV 219	Approximate			
/sician	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.  Immediate Cause (Final disease or condition  Sepsis											
ledical		Due to (only a consequence of):  Renal Failure Septic Shock							50.00			
miner		Sequentially list conditions.	t. +<		i Levesept	TC SHOCK		UNIZ II aw				
nsit	nlne	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	Due to a sa a consequence of):  Renal Failure								
physicien and s the burial-transit	i Examiner	that initiated events resulting in death) Last	c. Due to (or									
	edicai		d									
the attending phed for use as	Physician/M	FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23d. Date   1   Unknown   23d. Date   23							elivery Day Year			
igned by the a be detached f	by Phy								se contribute to the cause of death?			
n sig uld blu	pe pe			·			1 🗌 Ye	s 2□No 3□F	Probably 4 Unknow			
as been si 2 should l	Completed				autopsy	24a. Was an autopsy autopsy 24b. Were autopsy findings a prior to completion of ca						
page 2	Co						perform 1 Yes 2	led? death?				
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hi				h (Check only one	9)				
his co	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa			4 Li Nursing no		nce 6 Other (Sp	ecify)			
his II dii		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurre Work?										
his			2 Accident investigation M 1 Yes 2 No									
After this funeral dir		2 ☐ Accident investiga	t be		4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  5 Hace of Injury - At home, farm, street, factory, office building, etc. (Specify)							
After this funeral dir		2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 28e. Pface of	Injury - At home, farm, s etc. (Specify)	ireer, ractory, onice		City of Town,					
After this funeral dir	Certification:	2 Accident 3 Suicide 4 Homicide  29a. Certifier  29a. Certifier  29c. Certifier	28e. Pface of building,  Physician: To the becaminer: On the basis	etc. (Specify) est of my knowledge, deas of examination and/or	ith occurred at the tin	ne, date and place, pinion, death occur	and due to the ca	use(s) and manner a	as stated. ue to the cause(s)			
After this funeral dir	Medical Certification;	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  20 Medical Expansion	28e. Pface of building,  Physician: To the becaminer: On the basis and manner	etc." (Specify)  est of my knowledge, dea s of examination and/or stated.	ath occurred at the tin	pinion, death occur	and due to the ca red at the time, da	use(s) and manner atte and place, and du	to the cause(s)			
After this funeral dir	Medical Certification;	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  20 Medical Expansion	28e. Pface of building,  Physician: To the becaminer: On the basis and manner	etc." (Specify)  est of my knowledge, dea s of examination and/or stated.	ath occurred at the tin	pinion, death occur	and due to the ca red at the time, da	use(s) and manner atte and place, and du	ue to the cause(s)			
After this funeral dii	Medical Certification;	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	28e. Pface of building,  Physician: To the becaminer: On the basis and manner	etc." (Specify)  est of my knowledge, dea s of examination and/or stated.	ath occurred at the tin	pinion, death occur	and due to the ca red at the time, da	use(s) and manner atte and place, and du	to the cause(s)			

06-06547 Sushma Rao

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.							eg. No	20 C	16 2896			
Physicia		Decedent's Name (First, Middle)	e,Last)						2.	Date of Dea	th Day V	par	3. Time of Death	
edical Examir		SUSHMA RAO								Month Day Year September 1, 2006 1234 hrs				
		4a. Facility Name (if not institution, give street and number)				4b. City, Town	, or Loca	tion of D			4c. Count	y of Death	1	
		Frederick Memorial				Frederick				Frederick				
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If	Under 2	4Hrs_8	B Date of Bir	rth (MM/DD/YY)		thplace (State or	
Director		140-64-3126	1 M 2 <b>X</b> F	32	Yrs		Days	Hours	Min.	August	8,1974	Foreig	n New Jersey	
	-	Usual Residence of Decedent											Jersey	
È	ŀ	10a. State 10b. County		10c. City	, Town or Locat	ion							10d Inside City Limits	
_ %		Maryland Fr	rederick		Frederi	.ck							1 Yes 2 X No	
yland -f sh once		10e. Street and Number				10f. Zip Cod	10				0g. Citizen of V	Vhat Cou	ntry?	
Mar.	Directo	5794 Rockspr	av Court			101. Zip Coc		1702		Ι.	Unite		tates	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once.														
h wit	Funeral	11. Marital Status	Armed F	cedent Ever in U prces?		is Decedent o' 'es, specify Cu						ce - Amer ite, etc	ican Indian, Black,	
or its	ᆵ	1 Yes 2												
after	<u>\$</u>		or Dates:			1 Yes 2 X No specify:					Specify		dian	
natu		15. Decedent's Education (Spe		during		dent's Usual Occupation (Give kind of work g most of working life, DO NOT use retired					16b. Kind of I	Business/	Industry	
6 n 72 l	Completed	Elementary/Secondary (0-12)		1-4 or 5+) <b>5+</b>	Phys	icians	Acc	sist	ant		Mod	ical		
withii er th	Ĕ			) i	Thys	ICIAIIS				ina Baidala	Maiden Surnan			
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica		17. Father's Name (First, Middle		ъ						irst, ivildate,	_			
2121 uld be fi Mental J marked	o Be	G. S		Rao	10h Mailin	a Addross /6		Vija		ol Bouto Nu	Ra mber, City or To		7 n Cada	
D 21 should I and Mei 7 is mar natic ev	Ĕ	19a. Informant's Name/Relations				-								
imore, MD 21215-0036 Pages and 2 should be filed within 72 hours after ment of Health and Mental Hygiene anti: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	- 3	G.S. Rao / Fa	ther	1 206	Place of Dispo					Date			nd 21702 Town, State	
more, M Pages I and 2 nent of Health a ant: If item 27	1	1 Burial 2 X Cremation	n 3 Removal fr		crematory or of		Comoto	,,	_	Jaio	Zoo: Ecoaiio	. Oily oi	Town, June	
Page Page nent c		4 Donation 5 Other S	pecify:	Fr	ederick				9/04	4/2006	Freder	ick,	Maryland	
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat	- 1	21. Signature of Funeral Service	Licensee		22. 1	Name and Add	ress of F	acılity	Stau	ffer	Funeral	Hom	es, P.A.	
E P P E	0 8	Raymonel	Deler	SOR	1	621 Opc	ossu	ntow	n Pi	ke/ F	rederic	k, M	D 21702	
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and												
/Medical	8 1	Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease Death												
Examiner		or condition resulting in death)		a consequence										
~~"		Sequentially list conditions, b.												
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause												
	ä	(Disease or injury that initiated												
cuted and transit	Ж	events resulting in death) Last  d.												
0,	n/Medical	\( \text{VINPENDED} \)   AMENDED   item#23a,27,28a-f,perME,g860.10/2/06 TT												
760, cate be ex physician the burial	led	IF FEMALE:	23c If yes	outcome of pre		,penul,	3860.	10/2/	06 1.	l	23d. Date	of deliver		
8760, tificate by ng physic as the bur	n/N	23b. Was decedent pregnant in t			-	etal death	3 E	Ectopic p	regnand	y	Month		Day Year	
Sox 687 leath certific e attending for use as t	icia		4 Pregnant at time of death 5 Other (Specify)											
Box 68 e death certi the attendin	Physicia	1 Yes 2 No 9 🗸 Ur	nknown 9 Unkr	iown										
O at the dache tache		Part II. Other significant condi	tions contributing t	o death but not	resulting in the	underlying ca	use giver	n in Part	I.				the cause of death?	
P.O ires that t signed by	d by								1Ye	1 Yes 2 No 3 Probably 4 V Unknow				
rds, require been should	ete									24a. Was			utopsy findings available completion of cause of	
COT law law has be 2 sh	Jdu				_						ormed?	death?		
tal Rectian: The certificate ector, page	Completed							D # /0		1 Yes	2 No	1 🗸 Y	es 2 No	
of Vital Records,  g Physician: The law requir  offer this certificate has been s  neral director, page 2 should i	Be	25. Was case referred to medic examiner?	Al Hospital:		<b>7</b>		Place of I				<u> </u>			
'hysi	70	1 Yes 2 No			ER/Outpatier		Injury at	٠ ــــــ ٠		Home 5	Residence 6		er: 	
n of ling P After funera	ï.	27. Manner of Death  1 X Natural 5 Per		e of Injury h, Day,Year)	28b. Time of					ed. Describe	now injury occ	urrea		
ttend death ctor: y the	atic	T Fel	nding estigation				Yes							
Division tal or Attendii rs after death. al Director: /	tific		uld not be	ce of Injury - At	home, farm, stre	eet, factory, of	fice build	ling, etc.	2	8f. Location or Town,		nber or R	ural Route Number, City	
Di pital o	Certification:	4 Homicide	ermined (Specify	<u> </u>				_	1					
Hos 24 h Fun etely		29a. Certifier 1 Certifying I	Physician: To the be	est of my knowle	edge, death occi	urred at the tin	ne, date a	and place	e, and d	ue to the cau	use(s) and man	ner as sta	rted.	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filted in by the it	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
F 3 F 5	ME	29b. Signature and title of certif		00 11	1	29c. L	cense nu	umber			29d. Date si	gned (Me	onth, Day, Year)	
		Muna	Diasil (	V,M.	17		D.C.M.E	Ξ.			September 2, 2006			
		30. Name and address of person	on who completed car	use of death (Ite	em 23a)	1					1			
		Melissa Brassell, MD				Penn Stree	et, Balt	imore,	MD 2	1201				
s	tate	31 Date filed (Month, Day Year SEP	6 2006 32.F	ristrar's Signa	ature	and .	-	`						
Regis		SEP 0	6 2006	STATE OF THE PARTY.	14									

			For State Registrar		State of Ma	ıryland	l / Depa <i>Cer</i>	irtment of l tificate of	Health a <i>Death</i>	and Me	ntal Hyg R	Jiene leg. No.	2006	28969
*	Physici /Medic		Decedent's Name (Fig. 1)  Evelyn		Radcliff	ē.					Date of Dea Month August	Day	Year 2006	3. Time of Death  3:31 A <sup>M</sup>
	Examin Funeral Director		4a. Facility Name (If not Maplewo 5. Social Security Numb 188 12 396	od Park	Place	(In yrs. la	st birthday) Yrs.	4b. City, Town,  Bethese If Under 1 Year  Months Days	la If Under	24 Hrs. 8.	Date of Birth (Month, Day	Mo:	ntgomery 9. Birthe Cour	/ place (State or Foreign nsylvania
	ס		Usual Residence of De				Town or Lo	cation				<u> </u>		Od. Inside City Limits
	8a-f sh	Director		iontgome:	ry	Bet	hesda	-						1 □ Yes 2 XNo
	with th	Dire	10e. Street and Number		m Dood Ar	± 10	2	10f. Zip Code 20814					en of What Cour	ntry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, Ita Medical Examination in Italia Be incitied at	by Funerai	9707 Old G  11. Marital Status  1 Never Married  3 XWidowed 4	2 Married	12. Was Decedent E Armed Forces? 1 DYes 2 XN If Yes, Give Year or Dates:	ver in H S	5. 13. V	Vas Decedent of Yes, specify Cul			y Yes or No- can, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	vithin 72 hounder.	Completed	15. (Specify o Elementary/Seconda	Decedent's Edu only highest grad ry (0-12)	ication le <i>completed)</i> College (1-4or 5	+)	(Give life. [	lent's Usual Occu kind of work done OO NOT use retire	durina mos	t of working			d of Business/In	dustry
2	filed v Hygie other t	e Co	17. Father's Name (Firs	st, Middle, Last)	4		Teac	ner	18. Mothe	er's Name (F	First, Middle,		hool Sumame)	
ylan	should be ind Mental i marked c	To Be	Carl A. Pa	ller					Amel	ia Za	lewski			
Mar	d 2 sho		19a. Informant's Name. Harry Q. R					g Address <i>(Str</i> ee 2. Brewer						Code) MD 20852
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other trai		20a. Method of Disposit	tion remation 3 🗆 F	Removat from State	Ar	ace of Dispo:	sition (Name of natory or other pla on Nation	100)	Date	9	20c. Loc	eation - City or To	own, State
Balti	permit. Departm Imports any inju		21. Signatura di Funera	al Service Licens	unes	1 00	33	Name and Addr Northern 4522L Le	Virqi	nia Fu	meral	Ser	vices	
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	Physician /Medical Examiner		disease or condition resulting in death)		Due to (or as			-						
	acuted nd transit	Examiner	Sequentially list conditi if any, leading to immercause. Enter Underlyin Cause (Disease or injustrat initiated events)	ng 1	Due to (or as a									
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	w requires that i been signed by should be deta	þ	Part II. Other significar	nt conditions co	ntributing to death bu	ıt n <i>o</i> t resul	Iting in the ur	nderlying cause g	iven in Part I			baccous es 2 <b>X</b>		ne cause of death?
Division of Vital Records,	: The law requ cate has been page 2 should	Completed									24a. Was a autop: perfor	sy med?	24b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of 2 No
ξ	sician s certifi iirector	To Be	25. Was case reterred examiner?	-	Hospital: 1 □ Inpatie	nt 2 🗆 E	R/Outpatien	t 3 DOA			Check only or		☐Other (Specif	ivi
ion of	To the Hospital or Attending Physician: The twithin 24 hours after death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page		27. Manner of Death	i ☐ Pending investigation	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Inju		280	d. Describe h			,,,,,,,
Divis	tal or Atters after de al Directo	Certification:	3 Suicide 6	Could not be determined	28e. Place of Injubulding, etc	ıry - At hor . (Specify)	ne, farm, stre	eet, factory, office		28f	Location (S City or Tow	treet and n. State)	Number or Rura	il Route Number,
	he Hospital n 24 hours a he Funeral pletely filled	edical	29a. Certifier 1 X (Check only 2 one)	Certifying Phy Medical Exem	sician: To the best of iner: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred at the restigation, in my	ime, date ar opini <i>o</i> n, dea	nd place, and ath occurred	d due to the c at the time, c	ause(s) a late and	and manner as s place, and due to	tated. o the cause(s)
		M	29b. Signature and title	of certifier		10	71		6259				25, 200	
	<b>3</b> 0		30. Name and address Ava Kaufn		ompleted cadse of de	eath (Item	23а) (Туре,		iscono	sin Ass			da, Md.	
4	Sta Registi		31. Date filed (Month, I	Day, Year)	32 Registra	ar's Signati	ure Go		LUCUIIS	LII AV	с., ве	cues	au, IIU.	

			1 - State Registrar	State of Marylar	-	artment of He		Mental Hy	giene Reg. No.2	006	28970
· · · · · · · · · · · · · · · · · · ·	n .	φ,	1. Decedent's Name (First, Middle, Last)					2. Date of De Month			3. Time of Death
	Physici /Medic		Joann Lou	ise Stedding				August		2006	9:20 PM
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or L	ocation of Death		4c. Co	unty of Death	
3 			Mandrin Chesapeake	Hospice House	е	Harwood			Anne	e Arund	el
le"	Funeral Director		213-28-4194	7. Age (In yrs.	1ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 04/02/1	iv, Year)	9. Birthp Coun Mary	
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ecation				1	0d. Inside City Limits
	daryli aho	ច	,								1 ☐ Yes 2 X No
	28a-	Director	Maryland Anne Arur  10e. Street and Number	idet   Fag	ewater	10f. Zip Code			10g Citizen	of What Coun	try?
	with Sa or	₫	4257 Carvel Lane			21037					Í
	ns 23	era		12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hisp	panic Origin? (Sr			1 State	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23e or 28e-f show supprigning or other traumatic avant, I'm Modical Exp. bitter Liast be multiped at ance.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No ff Yes, Give Year or Dates:		If Yes, specify Cuban,	Mexican, Puerto Specity:	Rican, etc.)		Black, White, ecify: Whi	etc.
Maryland 21215-0036	2 hou	be	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupati	ion		16b. Kind	of Business/Inc	
7	Z uic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	iring most of worl	king			·
212	d with	E	12	College (1-401 3+)	Homen	aker			Home		
פַ	other	Bec	17. Father's Name (First, Middle, Last)	-		1	18. Mother's Nam	ne (First, Middle	, Maiden Sui	тате)	
lar	Aenta Aenta rked	TO E	Lloyd Sake	ers				Ida La	sh1ey		
ary	2 should and Men la marke aumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street an	nd Number or Ru	ral Route Numb	er, City or To	wn, State, Zip	Code)
	1 and 2 Health tem 27 l		Ann L. Bell/ Daught			Carvel La		water,	Mary1a	and 210	37
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. I	Place of Dispo cemetery, cres	sition (Name of matory or other place)	) !	Date	20c. Locat	ion - City or To	wn, State
Ĕ	permit. Pages Department of I Important: If Ite any injury or of once.		4 Donation 5 Other Specify)		las Cre	ematory	8/3	24/2006	£dgewa	ater. M	aryland
a	permit. Departri Imports any inju		21. Signatura di Avnegali Sarvice Lipense	90	22	2. Name and Address	of Facility Geo	rge F.	Kalas	Funera	1 Home
<u> </u>	89 2 2 3		Ill call		29	73 So1ошоі	ns Islan	d Rd.,E	dgewat	er, MD	21037
- SISTER			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consect	rat o	distrus					
	/Medical Examiner		Todaking in addition	Due to (or as a consec	quence of):						
100		_	Sequentially list conditions,	Due to (or as a consec		cancer					
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	querice orj.						
	and and Il-trar	xan	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
8760,	cale be executed physicien and the burial-transit	<u>a</u>									
687	icate phys s the	edical									
	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	fF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy				23d	. Date of delive	rv
Вох	atte	cial	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pregnancy Other (specify)					Day Year
oʻ.	the cy the	Jysi	9 Unknown	9□ Unknown							
Vital Records, P.O.	s that ned b s deta	Y P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause given	in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
rds	quires l n signe							1 🗆	Yes 2□N	lo 3 ☐ Prob	ably 4X Unknown
<u>o</u>	w requir s been si should	Completed						24a. Was	an 2	4b. Were autor	osy findings available
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ta	ysician: The is certificate hadirector, page	a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2A No	1 🗆 Yes	2 L No
5	Physician: r this certific ral director,	To B	examiner?	lospitaf: 1   Inpatient 2	ER/Outpatier	Other		ome 5 Resi		Other (Specifi	d)
ō	ਦੂ ≑ ਲ	Ë	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			7
o	Attending ir deeth.	te	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		es 2 □No				
Division of	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At h	ome, farm, str	eet, factory, office				umber or Rura	l Route Number,
٥	alor s afte	Sert	4   Homicide	building, etc. (Speci	ny)			City or To	wn, State)		
	To the Hospital or Attending Ph within 24 hou's after deeth. To the Funeral Diractor: After th completely filled in by the funeral	Medical (	29a. Certifier 1½ Certifying Phys (Check only one) 2 ☐ Medical Examin	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my opir	e, date and place, nion, death occur	, and due to the rred at the time,	cause(s) and date and pla	d manner as st ice, and due to	ated. the cause(s)
	Fo th within Fo th	Me	29b. Signature v.d title of certifism			29c. Licence			29d. Date si	gned (Month, I	Day, Year)
}	. >F 0		Vaul()	_		DO	2047	017	Anorot	. 2/ <sub>1</sub> 200	6
			30. Name and address of person who co	impleted cause of death (ffe	m 23a) (Type	Print)		124	August	24, 200	O
	5			dgely Avenue, Su			Maryland	21401			
3 10	Sta	ite	31. Date filed (Month, Day, Year)	32. Red strar's Sign	ature	1	)				
	Registi		AUG 2 5	2006	St.	good.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [5] Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Mary Elizabeth Stauffer August 25 2006 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Berlin Nursing & Rehabilitation Ctr. Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days 1 □ M XXF 220-24-2134 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Falcon Bridge Rd. 21811 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner-Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Hare Agnes Kovne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Stauffer 33 Falcon Bridge Rd., Ocean Pines, Md. 21811 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 8-25-2006 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** recosdisease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably

Stauffer,

-			
Complet			24a. Was an autopsy performed? 1 ☐ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical	26. Place of Death (C	Check only one)
10	examiner? 1 ☐ Yes	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Winnersing Home	5 ☐ Residence 6 ☐ Other (Specify)
rtlfication:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	n (Month, Day Year) Injury Work?  I □ Yes 2 □ No	d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death o nation and/or inves	ccurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. ne, date and place, and due to the cause(s)
29b. Signature and	suite of certifier		29c. License number	29d. Date signed (Month, Day, Year)

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son who completed cause of death (Item 23a) (Type, Print) produloù, who last logicus Ferway Ferwat Fgl, De 19944 Melas

within 24 hours at To the Funeral D

cal

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 2 2006 28972 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2006 7:40 P M AUG. 26 ROBERT ALLEN SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Yrs. 1923 MARYLAND Director 16, 83 216-12-0641 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" any injury or other transmitted. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No QUEEN ANNE QUEEN ANNE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21657 USA 317 CROUSE MILL ROAD by Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1942–1945 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TIDEWATER PUBLISHING 12 CHEMICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GWENDOLYN JEANNETTE** BUSHELL HENRY ROBERT SMITH ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH L. SMITH/ WIFE 317 CROUSE MILL ROAD, QUEEN ANNE, MD 21657 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 8-30-2006 CENTREVILLE, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. pe 3 Probably 4 Unknown 1 Yes 2\ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 has certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۴ 1 Tes 2 ER/Outpatient 3 DOA this filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death Medical Certification: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No М investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Zithin 2 To the 29c. License number 29b. Signature and title of centifier 131336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Clarke 2108 W. Donais 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

		•	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of ertificate of		Mental Hy	giene Reg. No. 2006	28973
	Physici /Medic	al	1. Decedent's Name (First, Middle, La.  Arlan Schao	chter		T 4 62 T-	1	2. Date of De Month AUGUS	Day Year 75 2006	<del></del>
	Examir Funeral	er	4a. Facility Name (If not institution, given Calvert Manor  5. Social Security Number 6. S		(In yrs. last birthday	Risin	r If Under 24 H	rs. 8. Date of Bir	4c. County of Deat  Cecil th 9. Birt	thplace (State or Foreign
	Director		Usual Residence of Decedent	□ <b>X</b> M 2□ F	79 Yrs.	Months Day	s Hours Mi	Decembe	r 4,1926	NY
	h the Maryla r 28a-f shov	irector	10a. State 10b. County MD Cec 10e. Street and Number	i1	Rising				10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No  ountry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 23s-f show other traumatic event, If a Medical Exacultar must be profified at	by Funeral Director	1881 Telegrap  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	h Rd.  12. Was Decedent E Armed Forces?  120 Yes 2 D N If Yes, Give Year or Dates:	o WW II	2191 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Canaita	
21215-0	e filed within 72 ha al Hygiene. I other than "natu vent, Ire Modical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1·4or 5-	(Give	edent's Usual Occ e kind of work don DO NOT use reti uter Ana	e during most of w red)	vorking	16b. Kind of Business/	,
Maryland	2 should be file and Mental Hyg is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last, Jacob Schachter  19a. Informant's Name/Relationship (		10h Mail	ion Address (Stra	Sarah	Goodston	, Maiden Sumame) LC er, City or Town, State, 2	Tin Codel
Baltimore, Ma	0 0		Rebecca Cebula/D  20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation 5 Other (Specif	aughter	94 Wa 20b. Place of Disp cemetery, cre	arren Dr	Elktor		921 20c. Location - City or Salisbury,	Town, State
Baltii	permit. Page Department. Important: II any injury o		21. Signature 4 Superat Service Licer	<u>.                                    </u>	2	2. Name and Add Andrew G	ress of Facility Gee Fur	neral Hom Elkton,	ie	TID
8760,	Certificate be executed had been and had been and had been and had been as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or som shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	a consequence of):	ter the mode of d	ying, such as card	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)	ncy		23d. Date of del Month	ivery Day Year
Records, P.	v requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause o	given in Part I.	1 0	,	obably 4 Unknown
al Rec	The lay ate has page 2	e Completed	25. Was case referred to medical					1 □ Yes	prior to death?  No 1 Yes	topsy findings available completion of cause of
Division of Vital	ding Phys .r. After this funeral di	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not b			of 28c. In W	Other: 45 Nursing ury at ork? Yes 2 \( \text{No} \)	28d. Describe I	dence 6 □Other (Specific Notice)  downinjury occurred  Street and Number or Ru	
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc	."(Specify)			City or To		
	o the Hos ithin 24 h o the Fun ompletely	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of and manner sta	examination and/or is	nvestigation, in my	opinion, death oc	curred at the time,	date and place, and due	to the cause(s)
	With To Con		30. Name and address of person with the same address of person with the same and the same address of the same address	completed cause of de	eath (Item 23a) (Type		9/1463		AUGUST 28, 2	
	5+1 VA Sta	to.	RODNEY DOWH	m. D.O. 18	BI TOLEGI	ZAPH RD	AD, Kisin	4 201, n	D 21911	
	Regist		31. Date filed (Month, Day, Year) AUG 2 9	2008 Kee	r's Signature	Sparke				

Registrar DHMH 17 Rev 1/2001

State

4-9+1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 0 1 2006

fame and address of person who completed cause of death (Item 23a) (Type, Print)

111

32. ggistrar's Signature

225

29c. License number 362

11110 medical Con

06-06598 Christopher Snyder

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 28975

		1- For State Registrar	rtificate	of Death		Re	eg No	
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)				Date of Deat     Month	Day Year	3. Time of Death 1317 hrs
~~	1161	Christopher Donavan Charles S  4a. Facility Name (if not institution, give street and number)	snyder	4b. City, Town, o	r Location o	Septembe of Death	4c. County of Death	
		Union Hospital		Elkton			Cecil	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	•	) If Under 1 Ye Months Dar		Min.	Foreig	
		212–31–7681 1 M 2 F 16  Usual Residence of Decedent	5	Yrs.		March	21,1990 °°	untry) MD
any			y, Town or Lo	cation				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	or	MD Cecil		E1kton				1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Cour	ntry?
ith the s 23a o	eral D	200 Landing Lane Apt. A1  11. Marital Status 12. Was Decedent Ever in U	IS 13	Was Decedent of H		in? ( Specify Yes or No-	U.S.A.	can Indian, Black,
death v r items	Funer	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No		If Yes, specify Cuba			White, etc.	carringari, black,
after o	by F	3 Widowed 4 Divorced If Yes, Give Year	L	Yes 2 X N			Specify: Whi	
2 hours "natu		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)		dent's Usual Occupa g most of working life			16b. Kind of Business/l	ndustry
5-0036 led within 72 Hygiene other than the Medical	ompleted	10 –	Stud	dent			High Schoo	01
15-00 illed wit Hygien d other	ပ	17. Father's Name (First, Middle, Last)				s Name (First, Middle, M	laiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	To Be	Christopher C. Snyder  19a Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Stre		Donna Walls ber or Rural Route Num	ber, City or Town, State	Zin Code)
→ R D is if	-	Donna F. Huffman/Mother					1kton, MD	
ore, ME ses I and 2 s of Health au If item 27		20a. Method of Disposition 20b.  1 X Burial 2 Cremation 3 Removal from State	Place of Disport	position (Name of ce	emetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages lar Department of Hee Important: If ite		4 Donation 5 Other Specify: Gi	lpin N			September 1	Elkton,	MD
Baltimo permit. Page Departament of Important: injury or oth		21. Security of Service Licensee	22	2. Name and Address Andrew G	s of Facility Gee	Funeral Ho	me	·
Physician	•	23a Part I. Enter the disease, or complications that caused the death	h. Do not ente	259 E March	ainSt g, such as ca	Elkton, ardiac or respiratory arre	MD 21921 est, shock, or heart	Approximate Interval
IMedical. Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Head in uries						Between Onset and Death
.xummer		or condition resulting in death)  Due to (or as a consequence	of):					
	je.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of the conditions).	of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury triat mutated events resulting in death) Last  Due to (or as a consequence of	of):					
ecuted and transit		dd.						
al al	/Medical	X UNPENDED AMENDED item#23	3a,27,28	a-f,perME,g	859,9/1	.5/06 TT		
8760, ificate be up physicist the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	gnancy	Fetal death 3			23d Date of delivery  Month D	ay Year
Box 68's death certiff. The attending ed for use as	sician	Pregnant at time of d		Other (Specify)		programo,	I Works	ay tou
O. Bo t the dea	Phy	Part II. Other significant conditions contributing to death but not	resulting in th	e underlying cause	given in Par	rt I 23e. Did to	bacco use contribute to	he cause of death?
, P.O	Ď			,g -2	g.,		2 ✓ No 3 Prob	
rds, requir	Completed					24a. Was a		opsy findings available ompletion of cause of
teco	ошо					perform	med? death?	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2.	BeC	25 Was case referred to medical examiner?		26.Piac		Check only one)		
f Vit Physic er this	၉	1 Ves 2 No Hospital: 1 Inpatient 2 V  7 Manner of Death 28a. Date of Injury	ER/Outpation 28b. Time of		Other		Residence 6 Other	
ion of tending Pl eath. or: After the funera	tion:	1 Natural 5 Pending (Month, Day, Yeár)	12:36		Yes 2 v	No -		
ivisior or Attencafter death Director:	fica	2 X Accident Investigation 3 Suicide 6 Could not be		hin	A	28f Location (S	an struck by II treet and Number of Rui	al Route Number, City
Diversal cours al	Certification:	4 Homicide determined (Specify) highway	r			Elkton, M	ate) 203 W. Pul D	aski Highway
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  2  Medical Examiner: On the basis of examination a						
To the within 7 To the complete	Med	and manner stated.  29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mon	
		Patu aronica tolla	hun	O.C.	.M.E.		September 4, 200	06
	ł	30. Name and address of person who completed cause of death (Item	· ·					
		Patricia Aronica-Pollak MD. Assistant Medical		111 Penn S	treet, Ba	timore, MD 21201	· · · · · · · · · · · · · · · · · · ·	
St Regist	ate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signat	M. A	made 3				
DHMH 17 Rev 1/2	_	25. 1 5 5000 James N	ORIGIN	IAL				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

edna Snoddy T		State of Maryland / Department of Hea			2006	2007
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		Reg. N 2. Date of Death	3. Time	of Death
Medical Exami	. 1117	Leona Taylor	To a de la companya d	Month Da August 31, 20		) hrs
			Town, or Location of Death ensburg		4c. County of Death Prince George's	
Funeral			der 1 Year If Under 24Hrs	8. Date of Birth(M	M/DD/YYYY) 9. Birthplace (S	State or
Director		579-46-3869 1 M 2 XF 71 Yrs. Mon	hs Days Hours Min.	Oct. 23	Foreign Country) I	)C
	- 1	Usual Residence of Decedent		1000. 25	, 1934	
/ any		10a. State 10b. County 10c. City, Town or Location				de City Limits
and Fshow	ъ	Maryland Prince George Bladensburg				es 2 No
Mary 28a-	Director		p Code		Citizen of What Country?	
death with the Maryland or items 23a or 28a-f show must be notified at once.		0011	0710		nited States	
ath wi tems st be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spec	lent of Hispanic Origin? ( Spe ify Cuban, Mexican, Puerto I		<ol> <li>Race - American Indian White, etc.</li> </ol>	n, Black,
ter dez ", or i		1 Yes 2 1 No	2 X No specify:		Specify: Black	
urs afi tural' amino	d by	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usua	Occupation (Give kind of w		. Kind of Business/Industry	
72 ho n "na sal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of w	orking life. DO NOT use retire	ed)		
003( vithin ene er tha Medic	du		anagement Spe		U.S. Governme	ent
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	en Surname)	
212: vuid be Menta marke	To Be	Norman Betchel  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address	Viola S (Street and Number or R	Snoddy ural Route Number.	City or Town, State, Zip Code	e)
MD 2 nd 2 shou alth and 1 m 27 is 1	-	Walter Andrew Snoddy, Sr. / Nephew 12210 Cle	•			*
e, N I and Health item		20a. Method of Disposition (No.	ame of cemetery,	Date 20	c. Location - City or Town, Sta	ate
nor ages ant of at: If		1 K Burial 2 Cremation 3 Removal from State crematory or other place 4 Donation 5 Other Specify: Resurrection	Cemetery 9/1	2/06 C	linton, Maryla	and
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ligensee / 22. Name an	d Address of Facility			
Der De		putti M. Cleiler Boge 5538	Funeral Homes Marlboro Pike	Foresty	ille, Md. 2074	47
Physician		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest, s	shock, or heart Approx	timate Interval en Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Hypertensive atherosclerotic	cardiovascular d	isease		Death
		or condition resulting in death)  Due to (or as a consequence of):				
	ĕ	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  C. Due to (or as a consequence of).				
uted id ansit	ŭ	events resulting in death) Last   Due to (or as a consequence or).   d.			^	
50, te be executed ysician and burial - transit	ledical	IX UNPENDED AMENDED item#23a,27,perME,g860	10/11/06 TT			
68760, certificate be nding physici	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	, 10/11/00 11		23d. Date of delivery	
687 certific nding se as t	sician/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Others (Se		псу	Month Day	Year
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	ecity)			
· £ >-	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobaci	co use contribute to the cause	of death?
, P.O ires that t signed by	d by			1 Yes 2	No 3 Probably 4	<b>✓</b> Unknown
rds v requ s been should	ompleted			24a Was an autopsy	24b. Were autopsy find prior to completion	
ecc he lav are has	J W			performed	l? death? No 1 ✔ Yes	2 No
al R an: T ertific etor, p	ပ	25. Was case referred to medical	26.Place of Death (Check of	nly one)		
of Vital Records,  ng Physician: The law requir  ther this certificate has been s  meral director, page 2 should	To B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3			idence 6 🗸 Other: Scene	
n of ling P After funera		27. Manner of Death  1 X Natural 5 Panding  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		28d Describe how	injury occurred	
Sior Vitend death ctor: y the	atic	2 Accident Investigation	1 Yes 2 No			
Division tal or Attendii as after death al Director:	ertification:	3 Suicide 6 Could not be determined (Specify)	ry, office building, etc.	28f. Location (Stree or Town, State)	et and Number or Rural Route )	Number, City
ospitz hours unera ly fille	O	29a. Certifier	so time and place and	dua ta tha anna (a)		
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in r				;)
To with To com	Mec	and manner stated.	9c License number		d. Date signed (Month, Day,)	
		11 11 King -	O.C.M.E.	s	eptember 1, 2006	
0/1	- 2	30. Name and address of person who completed cause if death (Item 23a)				
ORU	li li	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 F	enn Street, Baltimore	, MD 21201		
	tate	31. Date filed (Month, Day, Year) 2. Registrar's Signature				
Regis	trar	SEP 0 8 2006 Man & April				

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death	lental Hygid Rej	ene 200	5 2897
			Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physici		Adele W. T	raber				Month August	27, 2006	2:50 p <sup>M</sup>
4	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
	Laurini		5912 Mustang Driv	e		Riverda1	l e		Prince Ge	orge's
	Funeral		Social Security Number 6. S	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Director		118-09-5198	□M 2፟፟፟  M 2	Yrs.	Months Days	Hours Min.	Sept. 16,		York
	D		Usual Residence of Decedent							
	how		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	e Ma	턍	Maryland Prince	George's R	iverdal	e				1 X Yes 2 ☐ No
	th th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ours after death with the Marylan rel', or iteme 23e or 28e-f ehow Examiner must be notified at	es .	5912 Mustang Driv	ve		20737		Ţ	J.S.A.	
	dea ea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:	, ,	0	
8	urai',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:					WI	ite
5	be filed within 72 hours after death with the Maryland stal Hygiene.  dother than "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be multised at	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done o	furina most of worki	ng 10	6b. Kind of Business/	Industry
2	Athin Page 1	g.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,	)			
2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Home	maker	18. Mother's Name	/First Middle M	Own Home	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the M.	Be							aloen Sumame)	
χĮξ	should nd Men marke umatic	은	Thomas Walsh		400 14 10		Delia O'			
Ja	12 st		19a. Informant's Name/Relationship (7	ype, Pnnt)					City or Town, State, 2	
	ges 1 and 2 should it of Health and Men if Item 27 is marke or other treumatic		Tom Traber - Son  20a. Method of Disposition	20h		Red App1 sition (Name of			Maryland Oc. Location - City or	
ō	Pages nent of hant of hant: If its		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	natory or other place	θ)			
Ë	tant:		4 □Donation 5 □Other (Specify	<u> </u>		National (	1 .		rlington,	0
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	see M	1373				neral Home attsville,	-
			23a Part1. Enter the disease, or comp	olications that caused the de	ath. Do not ent					Approximate
-	Physician		shock, or heart failure. List only of Immediate Cause (Final		1	1 T 6				Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Acute Cere		ular Inia	rction			3 Weeks
Н	Examiner			Athorogalo		ascular D	icasca			Decades
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		ascarar b	Iscase			Decades
	d d ansit	Examiner	Cause (Disease or injury that initiated events	C						
o,	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ficate be executed physicien and s the burial-transit	dical		d						
9	tifica ig ph as th	ed								
Вох	eath certific attending p	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of del	
	deat e attr	Cig	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of		Other (specify)			Month	Day Year
P.0	that the de ned by the a detached t	Å.	9 Unknown							
	es the igned be de	by F	Part II. Other significant conditions co			nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ď	w require been sign		Hypertension, Ten	iporal Arteri	tis			1 🗆 Yes	: 2∭ No 3 ☐ Pr	obably 4 Unknown
Records,	aw re ts be 2 sho	piet						24a. Was an	24b. Were au	topsy findings available
Ä	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed						autopsy performe	ed? death?	completion of cause of 2□ No
Vital		ø	25. Was case referred to medical				26. Place of Death			
<u>&gt;</u>	o s	To B	examiner? 1 ☐ Yes 2 🖔 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	t 3 DOA Othe	er: 4 🗆 Nursing Hor	me 5 🕅 Residen	ce 6 □Other (Spe	city)
J of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how	v injury occurred	
jo	Attending ir death. ector: After by the fune	atic	1 XNatural 5 Pending 2 Accident investigation		(2.)		Yes 2 □No			
Division	l or Attendater deat Director:	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Stre	eet and Number or Ru State)	ıral Route Number,
	pepitel or A hours after uneral Directly filled in by	Certification;		, , , , , , , , , , , , , , , , , , , ,						
	To the Hospitel or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 X Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deatl nation and/or in	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	01/		29c, License	number	296	d. Date signed (Mont	h, Dey, Year)
	(114)		" belong he	Man		D22	780	A	ugust 28,	2006
	(10)		30. Name and address of person who o							
-	BC		Peter M. Schissle			ay Center	Drive #4	∔30, Gre€	enbelt, MD	20770-3542
8	Sta Registi		SEP 0 1 2006	32. Registrar's Sig	nature					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar  1. Decedent's Name (First, Middle, La		aryland / D	epartment o Certificate	of Death	2. Date of Dea	neg. Ito.	3. Time of Death
	Physici		Antonino Termin					Month August		'ear
	/Medic Examin		4a. Facility Name (If not institution, gire	re street and number)		4b. City, Tow	n, or Location of Deat	th	4c. County of	
			9300 Kirkdale Ro	oad		Ве	thesda			gomery
	Funeral Director		578-60-1502	100 M 100 E	e (In yrs. last birth 71 Y	Months Da	ear If Under 24 Hrs ys Hours Min	8. Date of Birt (Month, Day Sept. 1	6, 1934	9. Birthplace (State or Foreign Country) Italy
	ow III		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man a-f eh	tor	Maryland Montgo	omery		Bethes	da			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Coo	le		10g. Citizen of Wh	at Country?
	23a	a	9300 Kirkdale Ro	oad		20	317		US	A
0030	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, in Maddall Examinational be natilized at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent   Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give   Year or Dates:		13. Was Decedent If Yes, specify (	of Hispanic Origin? (Suban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify: V	American Indian, White, etc. Vhite
2	2 hour		15. Decedent's F	ducation	16a. D	Decedent's Usual Oc	cupation		16b. Kind of Busi	ness/Industry
2 2	hin 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5	(	Give kind of work do life. DO NOT use re	ne during most of wo	rking		,
7	er the	Con	12			Chef			estauran	
מום	d oth	Be	17. Father's Name (First, Middle, Last Antonino Termin:					me <i>(First, Middl</i> e, ela Term	Maiden Sumame)	
>	2 should be f and Mental P is marked of reumatic eve	2			405	14 11: 4 11 (0)				. 7 0 11
<u>8</u>	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship				eet and Number or R			ate, Zip Code)
a D	s 1 and of Health Item 27 other tr		Michelina Termin:  20a. Method of Disposition	rello/ Mile	20b. Place of D	Disposition (Name o		Date	MD 20817 20c. Location - Ci	ity or Town, State
2	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			, crematory or other	L	ust 29, 006		
Dalitimo	그 문문 중		21. Signature of Funeral Service Lice	-	Metropol	tan Cremat	ory 2 dress of Facility in S			a, Virginia
Ď	Depared Impo		dames 5	Doday						ing, MD 20901
ľ	Physician		23a. Part1. Enter the disease, or comshock, of heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	the death. Do no	at enter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		atic Bucc a consequence of	cal Cance: ):	<u>c</u>			
		er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a cons squence of	hr.	<u> </u>			
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Ş	ifficate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as	a consequence of	):				
9/00,	hysici the bu	edical		_ d.						
Ď K	± on es		IF FEMALE:	23c. If yes, outcome	of prognancy					
. DOX	requires that the death certifi een signed by the attending hould be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date Month	
ŗ.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in t	the underlying cause	given in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
cords	en sig							1 □ Y	res 2□No 3	Probably 4 Dinknown
200	rsiclen: The law r s certificete has be lirector, page 2 sh	Completed						24a. Was autop perfor	rmed? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
<u> </u>	ysiclen: is certific director,	Be	25. Was case referred to medical examiner?		=5/===		26. Place of De	ath  Check only o		
5		2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatie					dence 6 □Other	
	ending Path. or: After I	atlon:	27. Manner of Death  1 Solatural 5 Pending 2 Accident investigation	1	ry 28b. Tir y Year) Inj	ury	njury at Work? I □ Yes 2 □ No	28d. Describe h	now injury occurred	1
DIVIS	To the Hospital or Attending Physicien: within 24 hours sites deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not to determined	building, etc	c."(Specify)	n, street, factory, off		City or Tow	vn, State)	or Rural Route Number,
	ne Hospi 24 hou ne Funer	Medical	29a. Certifier 1 Certifying Pi (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/	death occurred at the for investigation, in r	e time, date and plac ny opinion, death occ	e, and due to the ourred at the time, o	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier	1			ense number		29d. Date signed (	
,	70		1//	/ /		Y	nv 331	09	Augus	+ 25 2006
			30. Name and address of person who	completed cause of d	eath (Item 23a) (T 1 HWW/I	ype, Print) 3800	Reserv	JoirRo	1.NW, W	Jashing to
	Sta Registr		31. Date files (Month, Day, Year)	2006 32. Abgistre	ar's Signature	Coaste				

06-06512 Tyler J. Vorce

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ico or maryiana		tificate of		ia mentani	, 0	eg. No. 200	16 289
Physici		1 Decedent's Name (First, Middle	,Last)				<u>.</u>	2. Date of Deat	h	3. Time of Death
Medical Exami	ner	Tyler John Vor  4a. Facility Name (if not institution			1	0.1 7		August 30		1817 hrs
		Shady Grove Adventis	-		4	Rockville	r Location of Death	1	4c. County of Death  Montgomery	1
Funeral				e (In yrs. Ia	ast birthday)	If Under 1 Yea	ar If Under 24Hrs	s. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		215-41-5403	1XM 2F		. 2 Yrs.	Months Day			Foreig	<sup>untry)</sup> Maryland
any		Usual Residence of Decedent  10a. State  10b. County	÷	10c. City,	Town or Location	on				10d. Inside City Limits
ž .	⊱	Maryland Montgo	merv	Boyd	S					1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number		J		10f. Zip Code		10	og. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.		12812 West 01d				20841			JSA	
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ıneral	11. Marital Status 1 X Never Married 2 Ma	12. Was Decedent Armed Forces?	)	S. 13. Was	Decedent of Hi s, specify Cuba	spanic Origin? ( Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ifter d	y Fun	3 Widowed 4 Divo	1 Yes 2	X No	1	Yes 2X No	specify:		Specify: Whit	:e
hours a "natura" Examir	d by	15. Decedent's Education (Spec	fy only highest grade con	npleted)	16a. Decedent	's Usual Occupa	tion (Give kind of ver.	work done	16b. Kind of Business/I	ndustry
36 thin 72 h than "n edical E	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)			e. DO NOT use ret	irea)		
5-0036 led within 72 Hygiene other than other than the Medical	E	17. Father's Name (First, Middle, I	act)		Studer	ıt	18.Mother's Name	Amines Baladale B	School	
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	Be C	Roy Anthony Vor	*				Karen Ja		,	
212 ould bould by Ment mark	힏	19a. Informant's Name/Relationsh			19b. Mailing	Address (Stree			ber, City or Town, State	, Zıp Code)
MD rd 2 sho llth and m 27 is aumati	.	Roy Vorce/ Fath	er		12812	West 0	ld Balti	more Rd.	Boyds, MD	20841
nore, MD 2121 ages   and 2 should be fi nt of Health and Mental   it: If item 27 is marked other traumatic event,		20a Method of Disposition  1 X Burial 2 Cremation	3 Removal from St	20b. F	Place of Disposi gematory or oth	tion (Name of ce er place)	metery,	Date	20c. Location - City or	Town, State
Page Page nent c ant: or oth		4 Donation 5 Other Spe		Me	rematory or oth Lakemon morial	t Gardens	09/0	06/2006	Davidsonvi	ille, MD
Baltimore, MI permit Pages   and 2 s Department of Health at Important: If item 27 injury or other traum		21. Signature of Fune al Service L	icensee		22. Na	ame and Addres	s of Facility Rol	bert E.	Evans Funer	al Home
		23a. Part I. Enter the disease, or o	omplications that caused	the death					e, MD 20715	Approximate Interval
Physician Medical		failure. List only one cause of	n each line.	tile death.	DO HOC CHICK (II	e mode or dying	, such as cardiac c	i respiratory arre	st, shock, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hanging  Due to (or as a conse	equence of	f):					Bount
Same		Sequentially list conditions,	b							
	ji.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of	f):					
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760, ficate be e g physician the burial	/Medical	IF FEMALE:				perME, G86	63 <b>,</b> 1/16/07	7 TT		
876 Tificat ing ph as the	Š	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor  1 Live birth	ne of pregr	,	al death 3	Ectopic pregna	ancy	23d Date of delivery  Month	ay Year
Box 68 death certif the attending	sician	1 Yes 2 No 9 Unkr	4 Pregnant at	time of dea	ath =	er (Specify)			A.	
D. BC t the der by the a	Phys	Part II. Other significant condition	9 Onknown	hut not re	sculting in the ur	dorlying gauge	given in Bort I	23o Did tol	bacco use contribute to	the equal of death?
, P.O.	ğ	l and an anal angument	oon in builty to dead	- Dat Hot le	ssaiting in the di	idenying cause (	giverritt atti.		2 No 3 Prob	
ds, equire een si ould b	Completed							24a. Was a	n   24b. Were au	topsy findings available
Division of Vital Records, rate death as after death at Director. After this certificate has been steld in by the funeral director, page 2 should it	ā	(						autops perform		ompletion of cause of
tal Recidian: The certificate ector, page		25. Was case referred to medical				26 Place	e of Death (Check	1 Yes 2	No 1 V	s 2 No
Vita ysician his cer directo	o Be	examiner?	Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient		Othor		Residence 6 Other	<del></del> -
of \ ing Phy After th uneral	-	27. Manner of Death	28a. Date of Inju (Month, Day,Y	iry	28b. Time of In		ry at Work?		ow injury occurred	
ion tendiceath tor: A	흹	1 Natural 5 Pendi 2 Accident Invest			Fnd 5:05	.m   1□	Yes 2 No	subject	found hanging	
ivisior or Atteno after death Director:	Certification:	3 Suicide 6 XCould	not be 28e. Place of In		ome, farm, street		ouilding, etc.	28f. Location (S	treet and Number or Ru	al Route Number, City
Divis	Ser	4 Homicide determ	nined (Specify) re	esidenc	ce			Rd. Boyd	s, MD	d barchiore
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 buts after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ical		vsician: To the best of miner:On the basis of examiner							
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.		or investigation	29c. Licens		at the time, date a	29d. Date signed (Mor	
	-	111. 1.	,00 1X			O.C.			August 31, 2006	, Day, 10al/
		30. Name and address of person v	the completed cause of d	eath (Item	23a)					
- 		Melissa Brassell, MD	Assistant Medical	,	,	enn Street, E	Baltimore, MD	21201		
	ate	31. Date filed (Month Day Year)	2006 32. F (gistra	r's Signatu	M L	ALL B				
Regis	trar	JEP U	7 2000							

Description of the control of the co				1- State of Maryland / Department Certification	ent of Health and Nate of Death		iene og. No. 2006	28980
Country   Description   Country		Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	h Dav Year	3. Time of Death
Second Second Number   Control Action					ty, Town, or Location of Death	<del></del>	T	
The state of the s						<del></del>		
Top   December   Dec				1 M 2 X F		(Month, Day,	Year) 9. Birth	
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The property of the property o		death ims 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	cedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian,
The properties of the properti	036	ours after al', or Ite	by	1 Never Married 2 Married 1 Yes 2 No		o nican, etc.)	ToTh-	
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The property of the property o	121	within ene. than	dmc	Elementary/Secondary (0-12)   College (1-4or 5+)	,		Own	Home
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OOL Of Supering and Supering S	/lar			Frank Buttino	There	esa Unknov	wn	
OOL Of Supering and Supering S	/Jan	2 sho				·		•
Physician Moderate Program of Control (Speedy)   Fort Lincoln Centerty   2006   Brentwood, Maryland   Program of Control (Speedy)   Fort Lincoln Centerty   2006   Brentwood, Maryland   2001		1 and Health em 27		20a. Method of Disposition 20b. Place of Disposition //	Vame of	_		
Physician Medical Examiner  The Comment of State of Comment of Com	Į Į	ages ent of nt: If it		XIXBURAL 2 Cremation 3 CHemoval from State	ilaga	ıst 30,		
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Physician Modifical Examiner  The Company of the cause of sea fine. Including in death)  The Company of the cause of the company of the cause of the company of the cause of t	~ m	89 2 2 8		James & Dooley 500 Ur	niversity Blvd	, W, Sil	ver Spring,	MD 20901
Physician   Color   Companies   Color   Companies   Color   Companies   Color   Companies   Color   Companies   Color   Companies   Color   Companies   Color   Companies   Color   Color   Companies   Color   Colo				shock, it heart failure. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arre	st,	Interval Between
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Secure traily is to concludes, part of the part of t				Hypertension				
Due to (or as a consequence of):   Hypothyroidism   FFEMALE   236. Was decedent pregnant in the past 12 months?   1   yes 2   2No   9   Unknown   1   yes 2   2No   9   Unknown   1   yes 2   2No   9   Unknown   2   24. Was an 2   24. Was an 2   25. Was decedent pregnant at time of death of Debta   25. Was decedent pregnant at time of death of Debta   25. Was decedent pregnant at time of death of Debta   25. Was decedent pregnant at time of death of Debta   25. Was decedent pregnant at time of death of Debta   25. Was decedent pregnant at time of death of Debta   25. Was death of Debta   25.		P. Z	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			-	
FEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year		and trans	cami	that initiated events	se			
August 27, 2006  30. Name and address of person who completed cause of getth (Item 23a) (Type. Print) Allen Reilly, M.D. 713 (Midway Avenue, Mt. Airy, MD 21771	,60	be ex sician burial		But to (or as a consoquence or).				
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Registrar AUG 2 8 2006 France of France								

		i	For State Registrar	State of Maryland	-	artment of H			jiene <sub>eg. No.</sub> 2	006	28982
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	V	3. Time of Death
Н	Physici /Medic		ULA WX	LFORD				Month	27	Year	10459h
	Examin		4a. Facility Name (If not institution, give st	eet and number)		4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
			Sligo Creek Nursi				Spring			tgomen	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. In	a <i>st birthd</i> ay) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Cour	
			578-08-6012 Usual Residence of Decedent	83				9/27/19	122	Jama	.1ca
	nyland how		10a. State 10b. County	10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	e Ma Ba-f s	Director	Maryland Prince Geo	rge's Hya	ttsvil	1e					1X Yes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
	eath v	erai	6659 24th Place  11. Marital Status 12	. Was Decedent Ever in U.	S 13 1	2078		ecity Ves or No-	U.S.A	Race - Americ	can Indian
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036	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2 🛣 No	Specify:		Spe	cify: B1a	ıck
5	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show he Wedical Exam or must be multified at	Completed	15. Decedent's Educa (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of work	ing	16b. Kind o	f Business/In	dustry
12	within ane. Ihen '	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	0		0.16	n . 1	,
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Seam	stress	18. Mother's Nam	e (First, Middle, i		Employ	reed
an	ld be ental ked o	To Be	Caleb Walford					e White		,	
ary	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Heatth and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Exam or must be motified at	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street	and Number or Rur		, City or To	wn, State, Zip	Code)
ž	alth a street		Lorene E. Ferrigan	- Daughter	6659	24th P	lace, Hya	ttsville	e, Mar	yland	20782
ore	es 1 a of He of Herr f Item r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	1 00	ace of Dispo imetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locatio	on - City or To	own, State
Ĕ	Pag ment ent: b		'4 ☐ Donation 5 ☐ Other (Specify)	Geo	rge Was	hington Ce	metery 9/	1/2006	Hyatts	sville	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healinportent: If Item 2 eny injury or other 2000g.		21. Signal of Funeral Service Licensee	L 40134			imore Ave				
г			23a Part I. Enter the disease, or complications shock, or heart failure. List only one	Itions that caused the death cause on each line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
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п	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	1	enter				
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	uted d ansit	Examine	any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events	Smatia	1000	Honor	anter	m			
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8760,	cate be executed physician and the burial-transit	dicai	d.			· · · · · · · · · · · · · · · · · ·					
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Вох	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	in the past 12 months?	<ul> <li>If yes, outcome of pregnar</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> <li>4 ☐ Pregnant at time of de</li> </ul>	death 3	Ectopic pregnancy				Date of delive Month	ery Day Year
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<u>α</u>	res that igned by be deta	by Ph	Part II. Other significant conditions contr	ibuting to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did toi	oacco use c	ontribute to th	ne cause of death?
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Ä	The law	E o						autops perforr	ned?	death?	mpletion of cause of
ita	ien: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat		7.		
	Physicien: The la r this certificate has ral director, page 2	2	1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ 6	ER/Outpatien		4 Nursing Ho	me 5 Reside	ence 6 🗆 (	Other (Specif	y)
Division of	ding Ph h. After thi funeral	iuoj:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	ς?	28d. Describe ho	w injury occ	curred	
Sic	Attending r death. ector: After by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ma farm etre		Yes 2 □No	28f. Location (St	root and Nu	mher or Rura	al Route Number
Di≤	l or A after Direct I in by	ertif	4 Homicide determined	building, etc. (Specify	)	set, factory, office		City or Town		mber or riara	THOUSE TABINDES,
_	To the Hospital or Attene within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physic	cian: To the best of my know	vledge, death	occurred at the tim	ne, date and place,	and due to the ca	ause(s) and	manner as si	lated.
	n 24 he Fu he Fu	edical	(Check only 2 Medical Examine one)	r: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my of	oinion, death occur	red at the time, d	ate and plac	e, and due to	the cause(s)
	To the To the comple	Σ	29b. Signature and title of certifier	C. 0		29c. License		2	9d. Date sig	ned (Month,	Day, Year)
	11)		> STILL	1100		V46	998		Mazu	1127	1 200 0
	Caro		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)	998 THYA1	1/1/1/10	Mr	200	Ó
	- CV	to	31. Date filed (Month, Day, Year)	3415 HC	ure	c (VI) J	1 11741	170114	1111	201	UZ-
	Sta Registr		SEP 0 1 2000	we to do			V				

State of Maryland / Department of Health and Mental Hygiene 2006

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			1 - State Registrar		Cer	tificate of	Death	F	Reg. No.		
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death
	Physici		John William	Warnick				August	4, 200	Year 06	350 A M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death			ty of Death	
	LAdiiii	iei	Oakland Nursing 8		ar	0ak1				arrett	t
	F		5. Social Security Number 6. Sep		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		_	place (State or Foreign
	Funeral Director			(M 2□F 82		Months Days	Hours Min.	(Month, Day	r. Year)	Coun	Virginia
			Usual Residence of Decedent		T			NOV. 20	, 1921	West	viiginia
	land		10a. State 10b. County	10c. (	City, Town or Loc	cation				1	IOd. Inside City Limits
	f sh	5	MD Garret	z t	Sw	anton					1 ☐ Yes 2 🔯 No
	28a	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	atar?
	E o Mit	급							-		iuy:
	s 23	ara .	3744 Swanton Road	10 Was Daniel 5	11.0	2156				JSA	
	er de	S		12. Was Decedent Ever in Armed Forces?	0.5.   13. V	Yas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ice - Americ ack, White,	
36	s aft	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💥 No If Yes, Give Year or Dates:	1	☐Yes 2X No	Specify:		Specia	fy:	√hite
8	hour ture	ğ			160 Deced	landa Harral Carre			405 Kind of 5		
5	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show to Medical Examinat must be notitled at	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give )	lent's Usual Occup kind of work done	during most of work d)	king	16b. Kind of E	Jusiness/inc	Justry
12	withi	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		reman.	4)		Poi1	lroad	
2	filed Hygid Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg		17. Father's Name (First, Middle, Last)			. I Cilicii	18. Mother's Nam	o /First Middle			
ä	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, The Ma	Be	William Thomas	Warnick			Bessie			riend	1
Ž	should I	2							-		·
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar f Heath and Mental Hyglene. I heath and Mental Hyglene. I heath as 23a or 28a-f show tiem 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, I'm Madical Examinal must be notified at		19a. Informant's Name/Relationship (Ty	•			and Number or Rui				Code)
	1 and 2 Health tem 27 i		Patricia Paugh/ Da				d, Oaklar	ACHIEL III		21550	
ore			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	1	Place of Dispos cemetery, crem	sition (Name of natory or other plac		Date	20c. Location	- City or To	wn, State
Ē	Pages nent of I ant: If its ury or o		'4 ☐ Donation 5 ☐ Other (Specify)	De	er Park	Cemeter	y 8/5/	/06	Deer P	ark,	MD
Baltimore,	permit. Pages 1 au Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Services cense	90	22.	. Name and Addre	ss of Facility	32 S.	Second	St.	
m	Depa Impo any is		1 Sedly Hally		St	ewart Fu	neral Hom	ne Oakla	nd, MD	2155	0
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de	ath. Do not ente	or the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Discontinues:		Immediate Cause (Final	atherosu	10 47	1.	1 20 2 9	- 1.	20000000		Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		year						
	Examiner						J				
		آو ا	Sequentially list conditions,	Due to (or as a cons	ouence of						
	led nsit	Examiner	cause. Enter Underlying Cause (Disease or injury								
_	certificate be executed iding physician and ise as the burial-transit	хаг	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
68760,	be e ician buria			,	, , , , , , , , , , , , , , , , , , , ,						
87	cate phys the	//Medical		l							
9 xc	ncertifi nding use as	Me	IF FEMALE:	On If was nutsame of season							
Bo			23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3 🗌	Ectopic pregnancy	/			ate of delive onth	ery Day Year
	The law requires that the death ate has been signed by the atter page 2 should be detached for u	Physicla	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5∐	Other (specify)					,
P.0	at th	F.						II an all			
	es th igner		Part II. Other significant conditions con	stributing to death but not re	sulting in the un	iderlying cause giv	en in Part I.		_		ne cause of death?
ğ	w require been sig	ed	- Communicat	ing nya	rocep.	holus		1 ⊔ Y	es 2 □ No	3 🗌 Prob	ably 4 Unknown
ပ္ထ	awr Is be	Completed by	10LP brovesc	wlow dis	euse			24a. Was a		Were autor	psy findings available
ď	i <b>icien</b> : The lav certificate has rector, page 2	E						autops perfor	med?	death?	impletion of cause of
tal		e e	25. Was case referred to medical			*	26. Place of Deat			10103	20110
of Vital Records,	Physicien: this certific	To B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1   Inpatient 2	☐ ER/Outpatient	3 DOA Oth		ome 5 Reside		ner (Snecih	z)
	Phys ar this aral dir		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur		28d. Describe he			7
5	ding th. fun	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2∐No				
is.	Atter dea ctor y the	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, stre	et, factory, office		28f. Location (S	treet and Numb	ber or Rura	l Route Number.
Division	after after Dire	Certification:	4  Homicide determined	building, etc. (Spec	city)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)		
_	spite ours erel		29a. Certifier 1 Certifying Phys	sician: To the best of my kr	nowledge death	occurred at the tin	ne date and place	and due to the c	ause(s) and m	anner as et	ated
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my o	pinion, death occur	red at the time, d	late and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signe	ed (Month, I	Day, Year)
gc_	F ≱ F 8		MALE SE	Vier	1/10	DA	119 0-10		_		
			11111111	10000	-191,	110	0 47 17	7	rug.	7)'	7, 2000
	6		30. Name and address of person who co	A / a	h. h	PIND P	A > 71/7	7 X	doit	MA	4.2006
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	nn MI.	1,100	VX 241	, ACCI	ueni	1-002	
	Sta		ALIG = 7	2006	Ao.	A 10 -					

		-	For State Registrar	8	State of	Marylar	nd / Dep <i>Ce</i>	artme	ent of H ate of L	ealth a Death	and M	ental H	lygien Reg. N	<sup>e</sup> 200	16	28984
W			Decedent's Name (First, Midd	fle, Last)								2. Date of	Death			3. Time of Death
	Physicia		Carrie	Ali	ce				Wil	17	9	Month	nher		Year Pcilo	03:46 AM
	/Medic Examin	aı er	4a. Facility Name (If not institution	on, give str	eet and num	iber),		4b. Cit	y, Town, or	Location of	of Death	2		c. County o		
			Ime Johnst	Tople	JNS	Hosp	ital	15	aft.	ina	re(	NY				
	Funeral		5. Social Security Number	6 Sex		7. Age In yrs.		) If Unc	ter 1 Year s Days	If Under	24 Hrs. Min.	8. Date of	Birth Day, Yea	r)	9. Birthp	lace (State or Foreign
	Director		213-40-3701	ייו	4 2 X F		66 Yrs.	1.0.11.1			J	an. 1	8,19	40	Mary	l'and
	pud *	-	Usual Residence of Decedent 10a. State 10b. Count			10c. Ci	ty, Town or L	ocation		_					1	0d. Inside City Limits
	sho	5														1 ☐ Yes 2 ☑ No
	286-1	ect	MD Garr  10e. Street and Number	err_		GLai	ntsvil.		Zip Code				10a C	itizen of W	hat Cour	ntry?
	with	ᄒ	492 Hare Hollo	D.d					1536							, .
	deeth with the Maryland ms 23a or 28e-f show	Funeral Director	11. Marital Status			dent Ever in U	J.S. 13.		cedent of Hi	spanic Ori	gin? (Spe	cify Yes or	USA No-	14. Race	- Americ	an Indian,
	fter d	듄	1 Never Married 2 Ma		Armed For	ces? 2√ZNo		If Yes, s	pecify Cuba	n, Mexican	i, Puèrto F	Rican, etc.)			, White,	
000	hours after turs!', or ite	Ď	3 X Widowed 4 □ Divorce	d	If Yes, Give Year or Da	в -		1 ☐ Yes	2 <b>XX</b> No	Specify:				Specify:	Whi	te
2	oe filed within 72 hours a al Hyglene. I other than "natural", o svent, the Micalical Exer-	Completed	15. Decede	nt's Educa	tion		16a. Dec	edent's Us	sual Occupa	ation	t of workin	ng.		Kind of Bus	iness/In	dustry
V	thin 6	ם	Elementary/Secondary (0-12)	331 9/200 0	College (1-	-4or 5+)	life.	DO NOT	use retired	)				arret		
V	ygien ygien t, the	S	10				Teach	ner,(	cook a							
and	iid be filed within 72 hours after deeth with the Marylan and the statistics of the statistics of the statistics from the recitities at its event, the Medical Examinar most be recitited at	Be	17. Father's Name (First, Middle	, Last)										n Sumame	)	
<u>X</u>	2 should be and Mental Is marked of raumatic sve	၉	Orvis Resh				1					e Hut				
	12 st h and 7 Is n traun	ĺ	19a. Informant's Name/Relation	snip (1ype	e, Pnnt)			•	ss (Street a						state, Zip	Code)
<b>a</b>	1 and Heelt sm 2 ther	}	Gary Wilt/Son 20a. Method of Disposition			20b.	Place of Disc	osition (A	503,	1		. <b>Le,</b> Mate		1536 Location - 0	City or To	own, State
وَ	ages nt of t: if it		Burial 2 ☐ Cremation		noval from S	State	cemetery, cre	matory o	r other plac	1		c 200				
аппо	artme orten Injury		4 Donation 5 Other ( 21. Signature of Fup ral Service	-		BIT	tinge:							tting		, P.A.
Ď	permit. Pages 1 and 2 should by Depertment of Heelth and Menia Important: If Item 27 is marked sny Injury or other traumatic stones.		I Lun	n	mai				Box 2						536	, i .a.
			23a. Part1. Enter the disease,	or complica	ations that ca	sused the dea										Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final	I only one			. 1	/ /		1						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	Due to (	or as a conse	quence of):	1 4	(~3-	7799	ige.				+	d days
	Examiner															
Ų	7 -	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>)</b> "	Due to (	or as a conse	quence of):									
	nd	Examiner	that initiated events	) c.												
Š,	e exe		resulting in death) Last		Due to (	or as a conse	quence of):									
2/20	cate b	dicai		d												
٥ ×	ding p	Me	IF FEMALE:	236	If yes out	come of pregn	ancy							1		
POX	etten for us	lan	23b. Was decedent pregnant in the past 12 months?	250	1 Live bi	rth 2 ∐ Fet ant at time of	al death 3	□Ectopic	pregnancy					23d. Date Mon		ory Day Year
j	the de	by Physician/Me	1 □ Yes 2 □ No 9 □ Unknown		9□ Unkno		3	_ Other	(Specify)				-			
	that led by deta	H.	Part II. Other significant condi	ions contr	ibuting to de	ath but not re	sulting in the	underlyin	g cause give	en in Part I		23e. D	d tobacco	use contri	bute to th	ne cause of death?
Records,	uires n sigr	d b	Prosthetic	mit	-al	valve	· (c)	0/90	Me	~+,		1	☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
င္ပ	w rec	ete	Anticogg							•		24a. W	as an	24b. W	ere auto	psy findings available
E C	The la te hes age 2	Completed	14016,50-19	1-1								pe	rformed?	de	nor to consath?	impletion of cause of
VItal	an: T	0	25. Was case referred to medic	al						26. Place	of Death	(Check on		10	162	2 NO
5	ysici is cer direc	To B	examiner?	Hos	spital: 1 1	npatient 2	] ER/Outpatie	ent 3	DOA Othe	er: 4 🗆 Nu	ursing Hon	ne 5□R	esidence	6 Othe	r (Specif	y)
0	ng Ph ter th neral		27. Manner of Death 1 Matural 5 ☐ Pend	ling		n Injury h, Day Year)	28b. Time Injury	of	28c. Injury Work	at	2	8d. Descrit	oe how inj	ury occurre	d	
<u> </u>	endir sath. or: Af he fu	atic	2 Accident inves	tigation				M		Yes 2□	No					
DIVISION	fract Iract	Certification:	3 Suicide 6 Coule 4 Homicide deter	mined	28e. Place buildir	of Injury - At h ng, etc. (Spec	nome, farm, s ify)	treet, fact	ory, office		2		n <i>(Str</i> eet a Town, Sta		r or Rura	l Route Number,
_	urs al		- Harri													
	Hos 24 ho Fun etely f	Medical	29a. Certifier Certify (Check only one)	l Examine	ir: On the ba	best of my kn isis of examin er stated.	ation and/or i	nvestigati	ion, in my of	ne, date an pinion, dea	ith occurre	ed at the tin	ne cause ne, date a	s) and mar nd place, a	ner as si	the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certification	er				1	29c. License	e number	September 3682 September 3682 September 3682			(Month,	Day, Year)	
			1 Ch	2,	.5	no			000	6368	25		Sem	temb	erz	2006
	S		30. Name and address of person	n who com	pleted caus	e of death (Ite	m 23a) (Type	, Print)			_		ť			
	(			Den.		600	10. 4	JOIF	e St.		15014	かのトル	, MI	> 5	128	7
(3)	Sta Registr		31. Date filed (Month, Day, Yea SEP		32. R	egistrar's Sign	ature	A	100 n							
				0 = 0		138 15 C. W. S.	15.5	Bar Star Bar	Control of the Contro							

			For State	State of Ma	ryland / [		rtment of H		Mental Hy		2006	28985		
			Registrer  1. Decedent's Name (First, Middle, Last,	)		0071	imouto or i		2. Date of D		2000	3. Time of Death		
	Physici		William Wayne Walt	ty					Augus	t 28	, 2006	7:30 AM <sup>M</sup>		
	/Medic Examir		4a. Facility Name (If not institution, give		<u>-</u>		4b. City, Town, or	Location of Dea			. County of Death	1		
			82 Maxwell Lane				North				Cecil			
	Funeral Director		313-20-4917	x 7. Age	(In yrs. last bir 76	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		av. Year)	9. Birthp Court Wichi	place (State or Foreign htry) Lta, KS		
	land W		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	Od. Inside City Limits		
	within 72 hours after death with the Maryland ene. then "neturel", or liems 23a or 28a-f show Its Modroll Exemiter mast be millised at	ţo	Maryland Cecil		Nor	rth	East					1 ☐ Yes 2 🔀 No		
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cour	ıtry?		
	th with	al D	82 Maxwell LAne				2190	1		Un	ited Stat	es		
	ems	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White,			
36	or it	y Fu	1 Never Married 2 Married	1 X Yes 2 ☐ N If Yes, Give	Korea	1	☐Yes 2█No	Specify:	,			nite		
Ö	hours turel	d by	3 ☐ Widowed 4X Divorced  15. Decedent's Edu	Year or Dates:	160	Doorde	anto Havel Ossuer	tion		105 10		4		
15	in 72	lete	(Specify only highest grad	le completed)		(Give k	ent's Usual Occupa kind of work done o O NOT use retired	fu <i>rina m</i> ost of w	vorking	160. K	ind of Business/Ind	Justry		
21215-0036	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		erk			Postal Service				
	il Hyg othe	BeC	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	rst, Middle, Maiden Sumame)				
lar	uld be Menta rrked	To E	William Albert	Walty				Edna M	innie Cla	ara V	Viechman			
Maryland	2 sho and h is ma	0.09	19a. Informant's Name/Relationship (T)							-	or Town, State, Zip	Code)		
	and and in 27 m 27	1	Michelle Dawn Noe	<u> </u>			xwell Lai	ne Nort	th East,					
Baltimore,	Jes 1 of H Hitel		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F	Removal from State	cemete	ry, crem	ition (Name of atory or other place Cremato:	nugi	Date 1st 29,		ocation - City or To			
ţ,	tmen tmen tent:		' 4 ☐ Donation 5 ☐ Other (Specify)	2006		wark, DE	1							
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-f show any july or other treumatic event. Ite Ms. Josef Exacilities must be n. Illied at Once.		21. Signature of Lines Special	low	Crouch Fi North Ea			1						
8760,	/Medical Examiner but sicial physician and physician and strength	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.								Onset and Death		
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at the 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of delive Month	o <b>ry</b> Day Year		
ds, P	ires that signed to d be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	n the un	derlying cause give	en in Part I.			use contribute to th			
Ö	v requir been si should l	etec							-					
al Records,	The lav	Completed		24a. Wa. autr							prior to con death?	psy findings available npletion of cause of 280 No		
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			- Othe		eath (Check only					
of	ding Physicien: The n. After this certificate hi funeral director, page	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	nt 2 ☐ ER/Ou y Year) 28b. 1	itpatient Time of Injury	28c. Injury Work	at ?	Home 5 kg Res 28d. Describe		6 □Other (Specify ry occurred	"		
Division	or Attending fler death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry · At home, fa . (Specify)	arm, stre		∕es 2⊡No	28f. Location City or To		nd Number or Rura a)	l Route Number,		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		(Check only 2 Medicel Exemi	sicien: To the best oner: On the basis of	examination an	e, death	occurred at the timestigation, in my op	e, date and pla- pinion, death oc	ce, and due to the curred at the time	cause(s)	) and manner as st d place, and due to	ated.		
	thin 2 the mplet	Medical	29b. Signature and title of certifi	and manner stat	ted.		29c. License	number		29d. Da	te signed (Month, I	Day, Year)		
	E W E			100					15					
/	+/VA		30. Name and address of person who co	ompleted cause of de	eath (Item 23a)	(Туре, Р	Print) Union	ave	War	1091	LUMD.	21678		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9	32. Regista 2006	r's Signature	K,	pole							

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 U U 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23,2006 **Physician** MELVIN WALKER AUGUST 0720 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Olney Montgomery General Hospital MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 26, 1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Director 5<u>77-46-2002</u> 71 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State f ehow 10d. Inside City Limits r then "naturel", or iteme 23a or 28e-f ehov the Medical Examinar must be notified at Director Montgomery Silver Spring 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'naturel', or Iteme 23a or 15711 Radwick Lane 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 t⊋ Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after d al Hygiene. 3 other then "naturel", or Item 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █No Specify: Š Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) 12th Bldg. Service Manager Schools injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Heelth and Mental I Important: If Item 27 Is marked o Clarence Walker Lillian Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret S. Walker (Wife) 15711 Radwick Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/29/06 Norbeck Mem Park Olney, MD 2 Sign tu Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. èn, 246 N. Wash. St., Rockville, MD 20850 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner physiclen end s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Hypertendion Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes Be director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: After completely filled in by the fun 5 Pending М 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD August 23 2006 039190 /0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garrett Reilly, M.D. 3418 Olandwood Court, Olney, MD 20832 32. Pagistrar's Signatura 31. Date filed (Month, Day, Year) State 28 AUG Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

CATHERINE

WILLIAMS,

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrat 28989 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** SEPTEMBER 4 2006 Mildred Jean Whisner 0145 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2፟XF Director June 21,1927 234-42-7602 Piedmont, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow 1 ☐ Yes 2 No Director wv Mineral New Creek 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Midway Lane P.O. Box 58 26743 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or itama 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 N Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced naturai White Completed Pages 1 end 2 should be filed within 72 homent of Health and Mental Hygiene.
ent: If item 27 is marked other than "naturury or other traumatic avent, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Tax Collector County Sheriff Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည Walter F. Ours Mildred O. Kight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Satorious A. Whisner/Husband P.O. Box 58 New Creek, WV 26743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If its
any injury or of 1 M Burial 2 □ Cremation 3 □ Removal from State Sept. 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2006 Keyser, WV 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Dulmonary /Medical Examiner sculitits pulmonary hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. မှ 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death
1 Natural
2 Accident 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Injury death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roule Number, City or Town, State) 4 \ Homicide within 24 hours e To the Funeral C completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number e of certifier 29d. Date signed (Month, Day, Year) DD018216 SEPTEMBER 2006 ess of person who completed cause of death (Item 23a) (Type, Print) 32 Hegistrar's Signature Seton Dr. Camberland, MO 21502 with MD 31. Date filed (Month, Day, Year) State SEP 1 2 2006 Registrar

			For State Registrar	State of	Maryland		artment <i>tificate</i>					giene Reg. No	ZIIIIb	28990
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Ī	Funeral	î	5. Social Security Number		. Age (In yrs. la				If Under	24 Hrs.	8. Date of Bir (Month, Da	h y, Year)	9. Bir	thplace (State or Foreign
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			for State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M	lental Hygi	iene 2 0 (	<b>J</b> 6	28991	
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: if Item 27 is marked other than. "natural; or Items 23s or 28s-f show appring to other traumatic event, Its Madical Examination and burntified at angle.		20a. Method of Disposition  1 □ Burial 2 □ Tremation 3  4 □ Donation 5 □ Other (Spec	☐Removal from	osition (Name matory or oth Cremat	-	Baltim	City or To	own, Slate						
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8760,	Physician but sicial but sicial but sicial and sicial sici	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Fant) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. ediate Cause (Final ase or condition lting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								ist,		Approximate Interval Between Onset and Death	
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Discounting of Discounting	2	11. Marital Status  1  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑	12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 2X No	panic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - America Black, White, e	
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		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R 4 □ Donation 5 X Other (Specify)	emoval from State	Place of Dispo cemetery, crer tro Cren	sition (Name of natory or other place)	0/19/2		c. Location - City or To	wn, State
once.	ĺ	21. Signature of Federal Physics dicent			Manual Address.	ck Rodin	ation Soci	altimore MD iety of MB, In Baltimore	Street -
160	dical Examin	23a. Pant1. Enter the disease of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	M DNA  uence of):  GE 1  uence of):	13 SE	PS15	espiratory arrest		Approximate Interval Between Onset and Death
Deby Calcion (Mac	ysicianyme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
Ī	2	Part II. Other significant conditions cor HEPATITIS C;	etributing to death but not res	ulting in the u	nderlying cause given アごう	in Part I.		cco use contribute to the	
o de la mon	_ ر	CASTRITIS;	PANCAEATI;	715 : A	NEMIA		24a. Was an autopsy performe	24b. Were autop prior to con death? 3 No 1 🗆 Yes	osy findings available inpletion of cause of 2 No
a	ם	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	iospital:	ER/Outpatier	Other	6. Place of Death		ce 6 ☐Other (Specify	
		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	The second second second	d. Describe how		,
Cortification	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Madical Examination	sician: To the best of my knower: On the basis of examina and manner stated.	owledge, death	n occurred at the time, vestigation, in my opin	, date and place, an nion, death occurred	d due to the caus at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)
2		29b. Signature and title of certifier  Jones V. N.	cognibel, m.	"	29c. License n			Date signed (Month, D	

State of Maryland / Department of Health and Mental Hygiene 2005 28993 For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day John Bell 1115 M 2004 5807 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nomico SAUSBURG MINSILA RAGIONAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F 219-52-8808 Yrs. Director 58 26, 1948 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Itame 23a or 28a-1 show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits MD Funeral Director Wicomico Salisbury 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 200 Civic Avenue 21804 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No II Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify. white 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 disabled none 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Carroll Bell Andranna Segalo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Jeani Vansternberg/sister 17116 Tribune Street Granada Hills, CA 91344 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □Donation 5 ☒ Other (Specify) in state 21. Sign ture Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Dire ctor Baltimore, MD 21201

23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TIC 2 HOCK **Physician** Iweek /Medical Due to (or as a consequence of): Examiner RESISTANT ST APHYLO CO CLUS METHICILLIN week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ARD IDMY OPATHY signed by the attending physicien and deedeched for use as the burial-transit certificate be executed SCHEMIC 34EARS Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۵ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24a. Was an autopsy performed?
1 ☐ Yes 2√2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes Division of Vital within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2. ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 962 SEPTEMBER 02,2006 REGIONAL MEDICAL CTR. MD 21801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M · SHIPAZI M.D. PENINS M. SHIRAZI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 3 2006 Registrar

			1 - For State of Maryland	/ Depa	artment of H	lealth and N Death	Mental Hy	giene 20 (	06 28991
Г	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
-	/Media	cal	Charlotte Ruth Bond 4a. Facility Name (If not institution, give street and number)		Ab City Town	Location of Death		30, 2006 4c. County of E	1:00 AM M
	Examir	ier	3502 St. James Road		Randall:		l	Baltim	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 214–40–5031 1 M 2 S F 96	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan 28		Birthplace (State or Foreign Country) ew Jersey
	pug 🔉		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryla 1 eho	tor	MD Baltimore		allstown				1 ☐ Yes 2√2 No
	or 28a	Director	10e. Street and Number	Range	10f. Zip Code			10g. Citizen of Wha	it Country?
	ath will	raiD	3502 St. James Road			21133		USA	Α
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If Itam 27 is marked other then "naturel", or iteme 23e or 28e-f ehow or other traumatic event, the Mudical Exacilinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Amed Forces?  1 □ Yes 2 ☑ No II Yes, Give Year or Dates:	If	Vas Decedent of H I Yes, specify Cuba □ Yes 2√2 No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	pecify Yes or No- p Rican, etc.)	14. Race - / Black, V Specify:	American Indian, White, etc. black
ည်	72 hou	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	kina	16b. Kind of Busin	ess/Industry
2	Mithin Then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired	)	, ing		
2	Hygie other	Be Co	12 4 17. Father's Name (First, Middle, Last)	<u>kinde</u> i	rgarten t		e (First, Middle,	_educatio Maiden Sumame)	on
<u>la</u>	should be ind Menta ind marked umatic ev	ToB	Clifton Moore			Anna Ma	arie Dow	ms	
Maryland 21215-0036	12 should hand 7 le ma		19a. Informant's Name/Relationship (Type, Print) Maria Broom/daughter					r, City or Town, Sta	
	tand Health tem 27 other tr		20a, Method of Disposition 20b. Pla	ce of Dispos	sition (Name of		Kandalls Date	town, MD 20c. Location - City	21133 y or Town, State
Baltimore,	Pages ment of a ant: If Its ury or o		4 ☑ Donation 5 ☐ Other (Specify)	netery, crem	atory or other plac	<del>θ</del> ) ¦			
Balt	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 It any Injury or other tra <u>once.</u>		21. Si nature Funeral Sarvie Licensee Ronald S. Wals Virector	St Ba	ltimore,	my Board MD 2120	1	Baltimor	e Street
,	Physician		23a. Paul. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of the consequence)	nce of):					0
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of).					
	xecuted and Il-transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of the consequence of th	nce of):					
8760,	cate be executed physicien and the burial-transit	dicai E	d. ==						
Ö	n certifica anding ph use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnant	ov.			1,510		
O. Box	death e atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
rds, P.	law requires that the de es been signed by the a 2 should be detached f	by	Part II. Other, significant conditions contributing to death but not result	ing în the un	derlying cause give	en in Part I.	23e. Did to	./	te to the cause of death?  Probably 4 Unknown
Vital Records,	e law requ hes been je 2 shouk	Completed	Mypertension				24a. Was a autop	sv prior	e autopsy lindings available to completion of cause of
ē	hyeician: The law his certificate hes b I director, page 2 s	e Co	25. Was case referred o medical	4re		00 Bl		med? deat	n? Yes 2□ No
₹	yeicia is cert directo	0 8	examiner? Hospital:	R/Outpatient	3□ DOA Othe	26. Place of Deat er: 4 □ Nursing Ho		ence 6 hother (S	Specify Home
Division of	Attending Physician: It death, Sector: After this certific by the funeral director,	ation: T	11 Z 1	8b. Time of Injury	28c. Injury Work			ow injury occurred	
	s after de	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	r Rural Route Number,
	To the Hospital or Attending Ph within 24 hours atten death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manne late and place, and	or as stated. due to the cause(s)
)	To the within 2 To the complet	2	29b. Signature and title of certifier  MM July		29c. License	0433	ż	SEPT, 06 Med 212	Jool G
			30. Name and address of person who completed take of death (Item 2 M D MY MD M3M C G) D		was st	Balli	more	Ma 212	204
Ą	Sta Registr	-	31. Date filed (Month, Day, Year)  SEP 1 3 2006  32. Registrar's Signatu	K A	esoli i				

				1 - For Stata Registrar	State of Maryla	ind / Depa	rtment of H	ealth and M Death	ental Hygier		28995
		Physici /Medi		Decedent's Name (First, Middle, La Edward Buerhaus					2. Date of Death Month D September	3, 2006	3. Time of Death  10:36 PM
-~	1	Examir	ner	4a. Facility Name (If not institution, given 2915 Eastern Bl	vd #20			altimore		lc. County of Deal Balt:	imore
	2	Funeral Director			ex 7. Age (In yr IXI M 2□F 6	s. last birthday) 4 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Dec 17, 19		hplace (State or Foreign nuntry) ryland
		h the Maryland or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltim		City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2√ No
		th with the 23e or 28a	al Director	10e. Street and Number 2915 Eastern Bl	vd #20		10f. Zip Code		unk 10g. 0	Citizen of What Co	untry? USA
	920	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or terms 23e or 28e-f show thit, the Middled Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Poivorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	11	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: wh	e, etc.
	Maryland 21215-0036	a filed within 72 hours I Hygiene "natural", other than "natural", ent, the Madical Ex-	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	ent's Usual Occupa kind of work done do DO NOT use retired)	uring most of worki	16b.	Kind of Business/	Industry unk
	yland ;	ges 1 and 2 should be filed it of Health and Mental Hyg if Item 27 is marked othe or other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Edward Buerhaus					(First, Middle, Maide		unk
Pr	, Mai	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship ( Edward Buerhaus J		17	g Address <i>(Str</i> eet a. Torque Wa		re, MD 2	r or Town, State, 2 1220	Tip Code)
36 pm	altimore,	permit. Pages 1 Department of Hi Important: If iter any injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 X Other (Specification)	Removal from State in state	Place of Dispos cemetery, crem	sition (Name of aatory or other place	,) D	ate 20c.	Location - City or	Town, State
10	Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licer	Wade lirecto	r St	Name and Address ate Anato Itimore,	my Board	655 W. Ba	ltimore	Street
		Physician /Medical Examiner		23a. Panil. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or a) a const	rointes	stinal b		r respiratory arrest,		Approximate Interval Between Onset and Death
9/2/10	8760,	certificate be executed triing physicien and tse as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a conse						
245	P.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
haus	ds, P	8 C 9	þ	Part II. Other significant conditions o	ontributing to death but not re	sulting in the un	derlying cause give	n in Part I.			the cause of death?
Buer	of Vital Records,	The law ate has b page 2 si	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 Ø N	death?	topsy findings available completion of cause of 2 No
	V:	ding Physician; h. After this certific funeral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	7.58/O		26. Place of Death 4 Nursing Hon		2 Flour (2	141
E	of		<b>-</b>	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work		8d. Describe how inj	6 □Other (Specury occurred	cify)
dward	Division	Attending or death. ector; After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At	Injury home, farm, stre	M 1 🗆 Y	es 2 No	8f. Location (Street a		ral Route Number,
E	۵	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu		29a. Certifier La Certifying Ph	building, etc. (Spec	nowledge, death	occurred at the time	a, date and place, a	City or Town, Sta	s) and manner as	stated.
		the Holin 24 the Fu	Medical	(Check only one) 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my opi				
		T S		1 Etso MD						ate signed (Monti	14,2006 21201
				30. Name and address of person who e	completed cause of death (Ite	om 23a) (Type, F - \$3\$	N Euta	wst F	Baltimora	MO	21201
	ia.	Sta		31. Date filed (Month, Day, Year)	32. an gistrar's Sign	nature &	sele!				

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 28996 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 **Physician** Month 10, Evangeline 2:20 Frances Burton Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Director Yrs 231-14-6588 29. 1920 West Virginia Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examena must by molified at 10d. Inside City Limits Director 1X Yes 2 □ No Virginia N/A Roanoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2906 Sweet Briar Ave. N.W. 24015 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Medical Exameranones. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify: White 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everette Ransom Alvis Eulalia Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Burton (Son) 50 South View Dr., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Birch Lawn 9/13/06 Pearisburg, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kendall Funeral Home P.O. Box 38, Pembroke, VA 24136 Mmen annes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2: certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2500 Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 XNatural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title g 29c. License number 29d. Date signed (Month, Day, Year) September 10, 2006 30. Name and address of person y completed cause of death (Item 23a) (Type 8 Ospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For State of Ma	ryland / Depa <i>Cen</i>	rtment of H tificate of L	ealth and N Death		giene 2006	28997
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Charles Francis Bauer			0	2. Date of Dea Month	Day Year	3. Time of Death 750 p M
	Examir		4a. Facility Name (If not institution, give street and number)  LOLIEN (Q) RIVERSIDE		Bei	Location of Death		4c. County of Death	′
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1213-28-9774 12 M 2 F 73	(In yrs. last birthday) _ } Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 1	, Year) Cou	place (State or Foreign ntry) .ryland
Maryland	f show	or	10a. State 10b. County Harford	10c. City, Town or Loc		tsville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	a or 28a- Lbe notiff	Director	Md.  10e. Street and Number  1376 Northbend Road		10f. Zip Code	084	1	log. Citizen of What Cou U.S.A.	
rs after death	Department of Health and Mental Hygiene. Important: if Item 23s or 28s-f ehow important: if Item 27 is marked other then "naturel", or Items 23s or 28s-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent E. Armed Forces?  1 ☐ Yes. 2 ☐ No. If Yes. Give Year or Dates:	o If	as Decedent of Hi Yes, specify Cubal	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: wh	
within 72 hou	then "nature or Medical E	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give k	O NOT use retired,	luring most of work )	ing	16b. Kind of Business/ir (telephone) communicati	
d be filed	ental Hygie ked other ic event, II	To Be Co	12 years  17. Father's Name (First, Middle, Last)  James Bauer	supply	manager	18. Mother's Nam		Maiden Sumame)	
od 2 shou	Ith and M 27 is mar r treumat	-	19a. Informant's Name/Relationship (Type, Print) Betty Jane Bauer		_	and Number or Rur	al Route Number	r, City or Town, State, Ziptsville, Md	
ages 1 ar	ant of Hea It: if item ? y or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposi cemetery, crema	ition (Name of atory or other place	9)	Date	20c. Location - City or To	own, State
permit. P	Departme Importan eny injur		21. Signature of Funeral Service Licensee					Bel Air, I	
1	Medical Medica	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	consequence of):	V (	O Cavel	~	of Lung	Approximate Interval Between Onset and Death
The law requires that the death certifica	by the attanding phached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
quires that	signed be de	þ	Part II. Other significant conditions contributing to death but	not resulting in the unc	derlying cause give	n in Part I.		pacco use contribute lo ti	
	rtificate has been stor, page 2 should	Completed					24a. Was an autops perform	v prior to co	psy findings available mpletion of cause of
r Attending Physicien:	fter this ce neral direc	Certification; To Be	25. Was case referred to medical examiner?  1	Year) 28b. Time of Injury	3 DOA Othe  28c. Injury Work  M 1 Y	at ? Nursing Ho at ? es 2 No	me 5 Reside 28d. Describe ho	once 6 Other (Specification of the second of	
o the Hospital or	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	edicai Cer	29a. Certifier (Check only one)  1 Certifying Physician: To the best of e and manner state	my knowledge, death o	occurred at the time stigation, in my op	e, date and place, inion, death occurr	and due to the ca	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
To the	within To the	Mec	29b. Signature and title of certifier	-112	29c. License	number	25	9d. Date signed (Month,	Day, Year)
	12		30. Name and address of person who completed radse of dea	ath (Item 23a) (Type, Pr	rint) 8 L	aw st	veet,	Xberde	en
	Sta Registr		31. Date filed (Month, 'Day,' Year)  32. Redistrar'	s Signature	and I	101910	vra	1001	,

			1 - For State Ragistrar	State of Maryland	d / Depa <i>Cer</i>	artment o	f Health and of Death	Mental Hy	giene Reg. No. 2 (	006	28	998
			Decedent's Name (First, Middle, Las					2. Date of Dea	ath		3. Time of	Death
	Physic /Medi		June E.	Burton				Month SEPTEME	Day BER 10	2006 I	:15	PM
	Exami	ner	4a. Facility Name (If not institution, give				n, or Location of Dea		4c. Count	•		
		*	BALTIMORE WA	HING-TON MED.	ICAL CT		LEN BC			VE A		
	Funeral Director		5. Social Security Number 6. Se 217–24–5612	711 -17-	78 Yrs.	If Under 1 Ye Months Da			h (, Year)	9. Birthplac	e (State o	r Foreign
			Usual Residence of Decedent		0			June oc	1928		NC	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d	. Inside Ci	ity Limits
	Mar Maritim	ctor	Maryland Anne Ar	rundel		G1e	n Burnie				1 🗌 Yes	2 🔯 No
	hours after death with the Maryland tural, or Items 23a or 28a-f show at Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of	What Country	?	
	ath w	rai	803 Marigold Road				21060		l	JSA		
	er de	nue	11. Marital Status	12. Was Decedent Ever in U.S Amed Forces?	S. 13. V	Vas Decedent of Yes, specify C	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rad Bla	ce - American ick, White, etc		
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1	☐Yes 2💢 t	No Specify:		Specif			
Ş	2 hou	edi	15. Decedent's Edi		16a. Deced	ent's Usual Oc	cupation		16b. Kind of B			
215	within 72 ene. than "nat	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give I	kind of work do OO NOT use rei	ne during most of we	orking	100.11110.01.0		,	
213	giene giene	E O	12	College (1-401 3+)	Me	ed <b>i</b> a Ai	de		Publi	ic Scho	ols	
pu	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle,	_	me)		
yla	Men Men arke	၉	William Seltm				Aida	М.	Bass			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importants if Item 27 ie marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Examiner must be notified at Once.	11	19a. Informant's Name/Relationship (7)				eet and Number or F				ide)	
	1 and Health		Bruce S. Burton 20a. Method of Disposition	(husband)	803 N	Marigol	d Road, G	_			2	
Baltimore,	ages nt of l		1 X Burial 2 ☐ Cremation 3 ☐ F	TOTAL TOTAL STATE		sition (Name of natory or other p	olace)   Sep	t 15	20c. Location			2004
Ħ	it. Per		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature 1 Fune al Service Lices			Veteran	is Cem	2006	Crownsv			
Ba	Depermine Depermine any it		21. Signature (1 Furneral Service Election)	* 1			aross or r donney	Stallings	s Funer	al Home	e, P.	Α.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ad, Pasac				A				
	Dhysisian	5 8	Immediate Cause (Final							lni Oi	proximate terval Betw nset and D	veen Death
	Physician / /Medical		disease or condition resulting in death)	a. INTRAC  Due to (or as a consequence)	ICAN	AL	HEME	PRHA	FG E	<u> </u>		
	Examiner					100	ATHO	^				
	7500	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):	1	1111/					7
6	nd nd transi	Examiner	mat minated events	c						- 4		
50,	The law requires that the death certificate be executed site hes been signed by the attending physicien and page 2 should be detached for use as the burran site.	Ë	resulting in death) Last	Due to (or as a consequent	ence of):							
8760,	ohysic the b	dicai		d								
9 ×	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregnan								
Вох	atten for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 🗌	Ectopic pregnal Other (specify)				te of delivery onth Da	y Y	'ear
P.O.	that the di ed by the detached	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	atti 5	Otrier (specify)						
J.	res thet the igned by be detact	¥ Y	Part II. Other significant conditions co.	ntributing to death but not resul	ting in the un	derlying cause	given in Part I.	23e. Did to	bacco use cont	tribute to the c	ause of de	eath?
Records,	n sign	d by	HYPERT	ENSION				1 🗆 Y	es 2,≝No	3 Probably	y 4 □U	nknown
00	s been s should	Completed	( HRONIC MB	STRUCTIVE	E PI	V MON	ARY DIST	Acr 24a. Was a	n 24b.	Were autopsy	findings a	available
Re	The lav	E		3//-0 ( / ///			1 7 100	perform	ned?	prior to comple death?	etion of ca	iuse of
ta		a l	25. Was case referred to medical	10-12-2-2-2		2000	26. Place of De	1 ☐ Yes : ath <i>Check</i> only on	/	1 ☐ Yes 2 ☐	] No	
of Vital	8 is 9	To B	examiner? 1 ☐ Yes 2 💢 No	łospital: 1 ⊠Inpatient 2 🗆 E	R/Outpatient	3□ DOA	7th ==	forme 5 ☐ Reside		er (Specify)		
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In		28d. Describe ho				
Sio	uttendi death. ctor: A y the fu	cati	2 ☐ Accident investigation				☐Yes 2 ☐No					
Division	or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, offic	<b>29</b>	28f. Location (St City or Town	reet and Numb n, State)	er or Rural Ro	oute Numb	)er,
	To the Hospital within 24 hours e To the Funeral Completely filled i		29a. Certifier 1 Certifying Phy	pician: To the best of	Janes de C			1				
	To the Hospital within 24 hours of the Funeral completely filled	Medical		sician: To the best of my know ner: On the basis of examination and manner stated.	neage, death on and/or inve	occurred at the estigation, in m	stime, date and place y opinion, death occi	e, and due to the caurred at the time, d	ause(s) and ma ate and place,	anner as stated and due to the	d. e cause(s)	
	ompl	Me	29b. Signature and title of certifier	. 0		29c. Lice	ense number	2	9d. Date signed	d (Month, Day	, Year)	
	C>F0		Same	i Jam 1	MD	DO	0618		-			1001
	1,6		30. Name and address of person who co	empleted cause of death (Item :	23a) (Type. P	Print)	0100	- 0	-1/21	DEF	1 .	2006
	10		SAMIR T	AIN 301	HO.	SPITA	06183 (CDR/1	IE GLE	NBURA	VIE MI	2 21	061
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ILO T	AP			,			

DHMH 17 Rev 1/2001

BURTON

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2:43 **Physician** Iris K. Bryan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 380 Hawthorne Court Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Days Hours Min. 219-20-4529 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Maryland Carroll Westminster Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21158 380 Hawthorne Court U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specity: White 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Manager Food Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest F. Koppen Mamie V. Wink 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 380 Hawthorne Ct., Westminster, Md. 21158 Dennis W. Gill - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If ite
any injury or ot 1 Deurial 2 □ Cremation 3 □ Removal from State New Lutheran Cem. Sept. 14,2006 Manchester, Md. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of une I Se Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 3 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Surcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct 4 🗍 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number title of certifier M completed cause of death (Item 23a) (Type, Print) ddress of person wh 555 South DESTHIUSTER MODIST AVIO 32 Registrar's Signature 31. Date filed (Month, Pay, Year) SEP 1 3 State Dar Registrar

			For State Registrar	State of Mary	and / Depa		Health and N	Mental Hy	/giene	_	290	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) C. Dorothy Be	enson				2. Date of D Month 09/0		2006	3. Time o 6:2	of Death 22 p M
1	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death			County of Death		
			Augsburg Lutherar			Baltin				ltimore		
	Funeral Director		213-07-3403	7. Age (In M 2⊠ F	yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 12/31	irth Pay, Year) 1915	9. Birth Cou Mar	place (State of Intry) yland	or Foreigr
	Maryland a-I show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore		Baltimo						10d. Inside C	City Limits
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?	
_	23a	al	6825 Campfield F			21207				ed Stat		
920	d within 72 hours after death with the Maryland Jiene. I then "netural", or Items 23a or 28a-1 show The Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N Bican, etc.)	1	4. Race - Amer Black, White Specify: Wh		
Maryland 21215-0036	C	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.		pation during most of word d)	king		d of Business/l thing	ndustry	
5	⊕ ₹ ₹ ₹		17. Father's Name (First, Middle, Last)		Sean	stress	18. Mother's Nam	ne (First, Middle				
and	B B B	To Be	William Walch				Christi					
ary.	2 should and Mer is marks aumatic	-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Address (Street	and Number or Ru				ip Code)	
	tra tra		Mr. C. Wayne Forre	st/Executor	3 Uni	on Hall	Court, Ca	tonsvi	lle, N	Marylan	2122	88
Baltimore,	of H of H ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  ☐ Conation 5 ☐ Other (Specify)	amount from State		sition (Name of matory or other pla ce Cemete		Date 1/2006		eation - City or T er, Mar		
Balti	permit. Page Department Important: II any injury o		11. Signature of Funeral Service License	Lin			ens Avenue		rünera	alHome,	Inc.	229
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the e cause on each line.  Clevelor  Due to (or as a cor	el Vo		accióo		arrest,		Approxima Interval Be Onset and	tween
3760,	ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor								
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		2:	3d. Date of deliment	2	Year
<u>α</u>	luires that the n signed by the	þ	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.			se contribute to No 3 ☐ Pro		_
Division of Vital Records,		Completed						per	s an opsy formed? 2 No	death?	ompletion of a	available cause of
VII;	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	- 177	· · O#	26. Place of Dea			<b>5</b>		
on of	fter	tion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	f 28c. Inju	ry at	ome 5 ☐ Res 28d. Describe		Other (Spec	ify)	
Divisi	al or Attar s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)		reet, factory, office			(Street and own, State)	i Number or Ru	ral Route Nun	nber,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (	(Check only 2 Medicel Exeminate)	sicien: To the best of my ner: On the basis of exa and manner stated.		vestigation, in my	opinion, death occu		, date and	place, and due	to the cause(s	s)
>	To t To t	Σ	29b. Signature and title of certifier  M. Shah	pari m	2	29c. Licens		+	Se F	signed (Month	. Day, Year)	5
	ID		30. Name and address of person who co Mundana Sh	mpleted cause of death の	(Item 23a) (Type, 25	Print)	63534	Rei	sters	stown	, MI	)

State Registrar

SEP 1 3 2006

